

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18-21 Film 312-31-18-21

13233

13269

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 424		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADAM Middle ABEND Last ABEND		4. DATE OF DEATH Month December Day 11 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1909
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 11 Days 19 Hours 58 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Balto. Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Adolph Abend	
14. MOTHER'S MAIDEN NAME Louise Schmidt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Roland Cox Box 415 Babikow Rd. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure secondary to Acute Alcoholism 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 322.0 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Exposure to cold			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Exposure to cold	
20c. TIME OF INJURY Month, Day, Year Hour ? o. m. ? p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Gambrills A.A. Co. Md.
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		DATE SIGNED 12/12/58	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-13-1958	22c. NAME OF CEMETERY OR CREMATORY St. Peters Lutheran	22d. LOCATION (City, town, or county) (State) Belair Rd. Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		24a. REC'D BY REGISTRAR DEC 16 '58	
ADDRESS 7401 Belair Rd.		24b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: Anna Arnold SEX: Female AGE: 37 OCCUPATION: Domestic

RESIDENCE: 1000 N. E. St. CITY: Baltimore COUNTY: Harford

DATE OF DEATH: April 10, 1920 TIME OF DEATH: 10:30 A.M.

PLACE OF DEATH: Home CAUSE OF DEATH: Heart

MODE OF DEATH: Natural MANNER OF DEATH: Natural

PREVIOUS ILLNESS: None PREVIOUS SURGERY: None

PREVIOUS TRAUMA: None PREVIOUS DRUGS: None

PREVIOUS ALCOHOL: None PREVIOUS TOBACCO: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

PREVIOUS OTHER: None PREVIOUS OTHER: None

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13270

CERTIFICATE OF DEATH

13234

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Camp Meade Road</u>		d. STREET ADDRESS <u>Camp Meade Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>E. Lynwood Anderson</u>		4. DATE OF DEATH Month Day Year <u>December 22, 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Warehouser Timber Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward S. Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mr. R. Lee Anderson</u>		Address <u>Glen Burnie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>CARCINOMA STOMACH</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-12-1958</u> to <u>12-22-1958</u> , that I last saw the deceased alive on <u>DOA</u> , 19 <u>58</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Blumenfeld</u> M.D.		ADDRESS (Street, city or town, state) <u>3904 S. HANOVER ST.</u>	
DATE SIGNED <u>12-26-58</u>			
PHYSICIAN'S NAME (Type) <u>SAMUEL BLUMENFELD</u>		<u>BALTIMORE, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard P. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13235

13271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 10 yrs. 10m 19d			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Silas Middle Anderson Last Anderson				4. DATE OF DEATH Month 12 Day 23 Year 19 58			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/17/39		9. AGE (In years last birthday) yrs. 19	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Silas Anderson				14. MOTHER'S MAIDEN NAME Rena			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralytic Ileus 570.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intestinal Obstruction by lemon peels DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) -----		
20f. (City or town) -----			20g. (County) -----			20h. (State) -----	
21. I certify that I attended the deceased from 1/14 , 19 48 , to 12/23 , 19 58 , that I last saw the deceased alive on 12/23 , 19 58 , and that death occurred on 4:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Benedict, M. D.				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 12/23/58			
PHYSICIAN'S NAME (Type) L. Benedict, M. D.				ADDRESS Crownsville State Hospital, Md. DATE SIGNED 12/23/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-27-58		22b. DATE THEREOF 12-27-58		22c. NAME OF CEMETERY OR CREMATORY St. Ambrose		22d. LOCATION (City, town, or county) (State) BALTIMORE, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Jackson				ADDRESS 916 N. Pennsylvania St.		24a. REC'D BY REGISTRAR DEC 29 58	
				24b. REGISTRAR'S SIGNATURE Caroline S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Journal of Management Education 30(6)p.789-804

—

1

100

13272

CERTIFICATE OF DEATH

Item 10, 11, 12, 13, 14 FilmG238 2-17-59 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A. County				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 316 Snow Hill Rd. Balt. 25 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Glen Burnie Md			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie Md				c. LENGTH OF STAY IN 1b 6 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PLAZA MANOR Nursing Home				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Rebecca Middle Bailey Last Bailey				4. DATE OF DEATH Month 12 Day 20 Year 1958			
5. SEX F.	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-1918	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Bailey				14. MOTHER'S MAIDEN NAME Mary Elizabeth ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO H.S. (C.V.D.) (Hypertensive Cardiovascular Disease). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis. (c) Generalized Atherosclerosis.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19	Month. 12	Day. 20	Year. 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/4 , 19 58 , to 12/20 , 19 58 , that I last saw the deceased alive on 11/12 , 19 58 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Munberg				ADDRESS (Street, city or town, state) P.O. Box 97 Odenton, Md			
PHYSICIAN'S NAME (Type) Robert G. Munberg				DATE SIGNED 12-23-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-23-58		22c. NAME OF CEMETERY OR CREMATORY Mount Calvary		22d. LOCATION (City, town, or county) (State) Arundel, Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Isaiah L. Brown & Son				ADDRESS 108 W. Montgomery St		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
				24a. REC'D BY REGISTRAR DATE FEB 2 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13273

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWPORT</u> <u>08X-2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNSVILLE STATE HOSPITAL</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H</u> Last <u>BARBOUR</u>				4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-1877</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM WORK</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HEILSON BARBOUR</u>				14. MOTHER'S MAIDEN NAME <u>HELENA PYE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> <u>11 days</u> DUE TO (c) <u>HYPERTENSIVE PNEUMONIA</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>12-16</u> , 19 <u>58</u> , to <u>12-27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-27</u> , 19 <u>58</u> , and that death occurred at <u>11 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Benedict M.D.</u>		M.D.		ADDRESS (Street, city or town, state) <u>Crownville State Hospital</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>				<u>Crownville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Dec. 31, 1958</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Newport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home W. Boy, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13274

CERTIFICATE OF DEATH

13237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT MEADE c. LENGTH OF STAY IN 1b 52 x 3 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2684-E MCARTHUR RD FT MEADE MD				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE INDIANA b. COUNTY FORT WAYNE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last EVA S BENTON				4. DATE OF DEATH Month Day Year DECEMBER 1st 1958									
5. SEX FEMALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 16th 1878		9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OSSTIAN, IND				11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE W STOVER				14. MOTHER'S MAIDEN NAME MARY E. DEAN									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 315-26-2551		17. INFORMANT JAMES J. BUTLER, COL 2684-E MCARTHUR RD							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS WITH MYOCARDIAL INFARCTION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH SUDDEN 10 Yrs													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) N/A													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) CARDIAC FAILURE				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 1600-1750 9 58				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) FT MEADE		(County) ANNE ARUNDEL		(State) MD	
21. I certify that I attended the deceased from DEC 1 , 19 58 , to DEC 1 , 19 58 , that I last saw the deceased alive on 7th , 19 58 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) US Army Hospital Fort George Meade DATE SIGNED 12/1/58													
ACTUAL SIGNATURE Leon EKassel				M.D. US Army Hospital Fort George Meade									
PHYSICIAN'S NAME (Type) William Cook, Inc., 1217 St. Paul Street													
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL				22b. DATE THEREOF 12-3-58		22c. NAME OF CEMETERY OR CREMATORY Lindenwood Cemetery		22d. LOCATION (City, town, or county) (State) Fprt Wayne, Indiana					
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street						24a. REC'D BY REGISTRAR DATE DEC 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines					

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

13275 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL Co., MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CHILDREN'S CENTER HOSPITAL LAUREL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LAWRENCE</u> First Middle Last <u>BEST</u>		4. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>m.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-22</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>no</u>	
11. BIRTHPLACE (State or foreign country) <u>German town, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DELANEY</u>		14. MOTHER'S MAIDEN NAME <u>ULLA - not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Father of FOREST HAVEN SCHOOL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>002X</u> <u>Bronchitis</u> DUE TO <u>Tuberculosis of lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Epilepsy</u> DUE TO (c) <u>Mental Deficiency</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12-4-58</u> <u>17 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental Deficiency</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-4-</u> 19 <u>58</u> , to <u>12-21-</u> 19 <u>58</u> , that I last saw the deceased alive on <u>12-21-</u> 19 <u>58</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Class</u>		ADDRESS (Street, city or town, state) <u>CHILDREN'S CENTER</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>GEORGE CLASS M.D.</u>		<u>LAUREL MARYLAND.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>DEC 23, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL CEM. SAILLAND RD. PRGEO. MD.</u>		22d. LOCATION (City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Evans</u>		24a. REC'D BY REGISTRAR <u>DEC 24 '58</u>	
ADDRESS <u>WASH 12, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13276 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Same</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>207 Baltimore Annapolis Blvd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ignacy</u> Middle <u>Blachovicz</u> Last				4. DATE OF DEATH Month <u>December</u> Day <u>3rd.</u> Year <u>19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years last birthday) <u>99</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer.</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Poland, Europe.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>			13. FATHER'S NAME <u>Unknown</u>				
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Mrs. Augusta Lipin (daughter)</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Aterio Sclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>March 1958</u> , 19 <u>58</u> , to <u>Dec. 4th.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 3rd.</u> , 19 <u>58</u> , and that death occurred at <u>1.30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u> DATE SIGNED <u>12/4/58</u>							
ACTUAL SIGNATURE <u>Eustace H. Fairbairn M.D.</u>							
PHYSICIAN'S NAME (Type) <u>Eustace H. Fairbairn, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)			
<u>Burial</u>	<u>Dec 6 '58</u>	<u>Holy Cross Cemetery</u>	<u>Bethesda, Md.</u>	<u>Ad Co Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard A. Trip</u>			24. REC'D BY REGISTRAR DATE <u>DEC 8 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Charles J. Kneiss</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Q. Q.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Q. Q.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>325 Burnside Ave.</u>		d. STREET ADDRESS <u>1325 Burnside Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Blieve</u> Last <u>Blieve</u>		4. DATE OF DEATH Month <u>12-</u> Day <u>21</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Md. State Employee Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Anna G. Smith</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic - Cardio-Vascular Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 21</u> , 19 <u>58</u> , to <u>Dec 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>58</u> , and that death occurred at <u>7:10 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert L. Anderson</u>		ADDRESS (Street, city or town, state) <u>44 Southgate Ave. - Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Albert L. Anderson, M.D.</u>		DATE SIGNED <u>12/21/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Annis Cemt</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor Sr</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

CERTIFICATE OF DEATH

1933

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1-2-34

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1888</i></p>		<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>		<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF DEATH <i>Dec 10 1933</i></p>		<p>9. PLACE OF DEATH <i>Home</i></p>		<p>10. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>11. MEDICAL HISTORY <i>None</i></p>		<p>12. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>13. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>14. DATE <i>Dec 10 1933</i></p>	
<p>15. NAME OF DECEASED <i>John Doe</i></p>		<p>16. SEX <i>Male</i></p>		<p>17. AGE <i>45</i></p>		<p>18. DATE OF BIRTH <i>Jan 15 1888</i></p>		<p>19. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>20. OCCUPATION <i>Teacher</i></p>		<p>21. MARITAL STATUS <i>Married</i></p>		<p>22. DATE OF DEATH <i>Dec 10 1933</i></p>		<p>23. PLACE OF DEATH <i>Home</i></p>		<p>24. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>25. MEDICAL HISTORY <i>None</i></p>		<p>26. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>27. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>28. DATE <i>Dec 10 1933</i></p>	

13240 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Pearl Middle BRANDFORD Last BRANDFORD				4. DATE OF DEATH Month December Day 12 Year 1958			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1903	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records A.A. General Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with 433.1 DUE TO fibrillation & circulatory failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia (c) Common Cold PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 8 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	Month 12 Day 16 Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Sept 23, 1958 , to Dec 12, 1958 , that I last saw the deceased alive on 12-12 , 1958, and that death occurred at 10:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 45 Franklin Street, Annapolis, Md. DATE SIGNED 12-15-58							
ACTUAL SIGNATURE Edith Rodler				M.D. 45 Franklin Street, Annapolis, Md.			
PHYSICIAN'S NAME (Type) Edith Rodler							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		12-16-58		Mt of Md.		Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Annapolis, Md.				24a. REC'D BY REGISTRAR DATE DEC 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1921

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

33200

1921

PLACE OF BIRTH		PLACE OF DEATH	
Maryland		Maryland	
Date of Birth		Date of Death	
1900		1921	
Age at Death		Cause of Death	
10		Diphtheria	
Sex		Occupation	
Male		Student	
Marital Status		Place of Residence	
Single		Baltimore, Maryland	
Date of Marriage		Date of Admission to Hospital	
		May 15, 1921	
Date of Discharge		Date of Death	
		May 17, 1921	
Name of Physician		Name of Hospital	
Dr. J. H. Smith		St. Mary's Hospital	
Signature of Physician		Signature of Hospital	
[Signature]		[Signature]	
Name of Coroner		Name of Registrar	
Mr. J. H. Smith		Mr. J. H. Smith	
Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]	
Name of Undertaker		Name of Burial Place	
Mr. J. H. Smith		St. Mary's Cemetery	
Signature of Undertaker		Signature of Burial Place	
[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13241 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A. Counts</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>A. A. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Maryland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hospital</i>		d. STREET ADDRESS <i>4 Carver Street</i>	
3. NAME OF DECEASED (Type or print) <i>Agnes</i> First <i>Brent</i> Middle <i>Brent</i> Last		4. DATE OF DEATH <i>12-9-1958</i> Month <i>12</i> Day <i>9</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-1-1890</i>
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lewis Green</i>		14. MOTHER'S MAIDEN NAME <i>Henneretta Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Harrison Brent</i>		Address <i>4 Carver St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>493X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>DIABETES MELLITUS; ARTERIO SCLEROTIC HEART DISEASE</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>15 NOV</i> , 19 <i>58</i> , to <i>9 DEC</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>8 DEC</i> , 19 <i>58</i> , and that death occurred at <i>3 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward S. Keel</i>		ADDRESS (Street, city or town, state) <i>44 Birchgate Ave. Annapolis Md</i>	
PHYSICIAN'S NAME (Type) <i>Edward S. Keel</i>		DATE SIGNED <i>12/9/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>12-12-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Keel</i>		ADDRESS <i>108 Wash. St. Annapolis Md</i>	
24a. REC'D BY REGISTRAR <i>DEC 11 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Jones</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13242 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13243

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Bay Ridge</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4 Farragut Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LONDON</u> Middle <u>W. Mayes</u> Last <u>BROOKS</u>		4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William C. Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Nannie Mayes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-34-6362</u>	
17. INFORMANT <u>L. Scott Brooks</u>		18. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
19. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		20. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/16/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-18-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jessops Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Sparks, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Brooks</u>		24a. REC'D BY REGISTRAR ADDRESS <u>622 York Rd., Towson 4, Md.</u> DATE <u>DEC 22 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

200

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13244

13243 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Annarundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Annapolis General Hospital				d. STREET ADDRESS 1605 W. Lanvale Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frank Middle Last Butler				4. DATE OF DEATH Month Dec. Day 14 Year 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1885	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Butler				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Louise Butler Address 1605 W. Lanvale St. Balto., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia						INTERVAL BETWEEN ONSET AND DEATH 7 wk.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 13, 1958 , to Dec. 14, 1958 , that I last saw the deceased alive on Dec. 14, 1958 , and that death occurred at 12:30 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John L. Brademan M.D.				ADDRESS (Street, city or town, state) 121 Cathedral St.		DATE SIGNED 12/14/58	
PHYSICIAN'S NAME (Type) Annapolis, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/19/58		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Ann Arundel County	
23. FUNERAL DIRECTOR'S SIGNATURE A. Halstead ADDRESS 918 Druid Hill Ave.				24a. REC'D BY REGISTRAR DATE DEC 16 '58		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

CERTIFICATE OF DEATH

1915

1. PLACE OF DEATH		2. DATE OF DEATH	
3. NAME OF DECEASED		4. SEX	
5. AGE		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR	
9. PLACE OF BIRTH		10. DATE OF BIRTH	
11. PLACE OF DEATH		12. DATE OF DEATH	
13. CAUSE OF DEATH		14. MANNER OF DEATH	
15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF CLERK	
19. SIGNATURE OF JUDGE		20. SIGNATURE OF SHERIFF	
21. SIGNATURE OF CORONER		22. SIGNATURE OF JURY	
23. SIGNATURE OF DISTRICT ATTORNEY		24. SIGNATURE OF COUNTY CLERK	
25. SIGNATURE OF STATE CLERK		26. SIGNATURE OF SECRETARY	
27. SIGNATURE OF ASSISTANT SECRETARY		28. SIGNATURE OF CHIEF CLERK	
29. SIGNATURE OF DEPUTY CLERK		30. SIGNATURE OF RECORDS CLERK	
31. SIGNATURE OF INDEXING CLERK		32. SIGNATURE OF FILING CLERK	
33. SIGNATURE OF DISTRIBUTION CLERK		34. SIGNATURE OF RETURN CLERK	
35. SIGNATURE OF RECEPTION CLERK		36. SIGNATURE OF STORAGE CLERK	
37. SIGNATURE OF RETENTION CLERK		38. SIGNATURE OF RELEASE CLERK	
39. SIGNATURE OF REPRODUCTION CLERK		40. SIGNATURE OF REPAIR CLERK	
41. SIGNATURE OF REINFORCEMENT CLERK		42. SIGNATURE OF REWORK CLERK	
43. SIGNATURE OF REUSE CLERK		44. SIGNATURE OF REPAIR CLERK	
45. SIGNATURE OF REINFORCEMENT CLERK		46. SIGNATURE OF REWORK CLERK	
47. SIGNATURE OF REUSE CLERK		48. SIGNATURE OF REPAIR CLERK	
49. SIGNATURE OF REINFORCEMENT CLERK		50. SIGNATURE OF REWORK CLERK	
51. SIGNATURE OF REUSE CLERK		52. SIGNATURE OF REPAIR CLERK	
53. SIGNATURE OF REINFORCEMENT CLERK		54. SIGNATURE OF REWORK CLERK	
55. SIGNATURE OF REUSE CLERK		56. SIGNATURE OF REPAIR CLERK	
57. SIGNATURE OF REINFORCEMENT CLERK		58. SIGNATURE OF REWORK CLERK	
59. SIGNATURE OF REUSE CLERK		60. SIGNATURE OF REPAIR CLERK	
61. SIGNATURE OF REINFORCEMENT CLERK		62. SIGNATURE OF REWORK CLERK	
63. SIGNATURE OF REUSE CLERK		64. SIGNATURE OF REPAIR CLERK	
65. SIGNATURE OF REINFORCEMENT CLERK		66. SIGNATURE OF REWORK CLERK	
67. SIGNATURE OF REUSE CLERK		68. SIGNATURE OF REPAIR CLERK	
69. SIGNATURE OF REINFORCEMENT CLERK		70. SIGNATURE OF REWORK CLERK	
71. SIGNATURE OF REUSE CLERK		72. SIGNATURE OF REPAIR CLERK	
73. SIGNATURE OF REINFORCEMENT CLERK		74. SIGNATURE OF REWORK CLERK	
75. SIGNATURE OF REUSE CLERK		76. SIGNATURE OF REPAIR CLERK	
77. SIGNATURE OF REINFORCEMENT CLERK		78. SIGNATURE OF REWORK CLERK	
79. SIGNATURE OF REUSE CLERK		80. SIGNATURE OF REPAIR CLERK	
81. SIGNATURE OF REINFORCEMENT CLERK		82. SIGNATURE OF REWORK CLERK	
83. SIGNATURE OF REUSE CLERK		84. SIGNATURE OF REPAIR CLERK	
85. SIGNATURE OF REINFORCEMENT CLERK		86. SIGNATURE OF REWORK CLERK	
87. SIGNATURE OF REUSE CLERK		88. SIGNATURE OF REPAIR CLERK	
89. SIGNATURE OF REINFORCEMENT CLERK		90. SIGNATURE OF REWORK CLERK	
91. SIGNATURE OF REUSE CLERK		92. SIGNATURE OF REPAIR CLERK	
93. SIGNATURE OF REINFORCEMENT CLERK		94. SIGNATURE OF REWORK CLERK	
95. SIGNATURE OF REUSE CLERK		96. SIGNATURE OF REPAIR CLERK	
97. SIGNATURE OF REINFORCEMENT CLERK		98. SIGNATURE OF REWORK CLERK	
99. SIGNATURE OF REUSE CLERK		100. SIGNATURE OF REPAIR CLERK	

1. NAME OF DECEASED
2. DATE OF DEATH
3. SEX
4. AGE
5. OCCUPATION
6. MARITAL STATUS
7. PLACE OF BIRTH
8. DATE OF BIRTH
9. PLACE OF DEATH
10. DATE OF DEATH
11. CAUSE OF DEATH
12. MANNER OF DEATH
13. SIGNATURE OF PHYSICIAN
14. SIGNATURE OF WITNESSES
15. SIGNATURE OF REGISTRAR
16. SIGNATURE OF CLERK
17. SIGNATURE OF JUDGE
18. SIGNATURE OF SHERIFF
19. SIGNATURE OF CORONER
20. SIGNATURE OF JURY
21. SIGNATURE OF DISTRICT ATTORNEY
22. SIGNATURE OF COUNTY CLERK
23. SIGNATURE OF STATE CLERK
24. SIGNATURE OF SECRETARY
25. SIGNATURE OF ASSISTANT SECRETARY
26. SIGNATURE OF CHIEF CLERK
27. SIGNATURE OF DEPUTY CLERK
28. SIGNATURE OF RECORDS CLERK
29. SIGNATURE OF INDEXING CLERK
30. SIGNATURE OF FILING CLERK
31. SIGNATURE OF DISTRIBUTION CLERK
32. SIGNATURE OF RETURN CLERK
33. SIGNATURE OF RECEPTION CLERK
34. SIGNATURE OF STORAGE CLERK
35. SIGNATURE OF RETENTION CLERK
36. SIGNATURE OF RELEASE CLERK
37. SIGNATURE OF REPRODUCTION CLERK
38. SIGNATURE OF REPAIR CLERK
39. SIGNATURE OF REINFORCEMENT CLERK
40. SIGNATURE OF REWORK CLERK
41. SIGNATURE OF REUSE CLERK
42. SIGNATURE OF REPAIR CLERK
43. SIGNATURE OF REINFORCEMENT CLERK
44. SIGNATURE OF REWORK CLERK
45. SIGNATURE OF REUSE CLERK
46. SIGNATURE OF REPAIR CLERK
47. SIGNATURE OF REINFORCEMENT CLERK
48. SIGNATURE OF REWORK CLERK
49. SIGNATURE OF REUSE CLERK
50. SIGNATURE OF REPAIR CLERK
51. SIGNATURE OF REINFORCEMENT CLERK
52. SIGNATURE OF REWORK CLERK
53. SIGNATURE OF REUSE CLERK
54. SIGNATURE OF REPAIR CLERK
55. SIGNATURE OF REINFORCEMENT CLERK
56. SIGNATURE OF REWORK CLERK
57. SIGNATURE OF REUSE CLERK
58. SIGNATURE OF REPAIR CLERK
59. SIGNATURE OF REINFORCEMENT CLERK
60. SIGNATURE OF REWORK CLERK
61. SIGNATURE OF REUSE CLERK
62. SIGNATURE OF REPAIR CLERK
63. SIGNATURE OF REINFORCEMENT CLERK
64. SIGNATURE OF REWORK CLERK
65. SIGNATURE OF REUSE CLERK
66. SIGNATURE OF REPAIR CLERK
67. SIGNATURE OF REINFORCEMENT CLERK
68. SIGNATURE OF REWORK CLERK
69. SIGNATURE OF REUSE CLERK
70. SIGNATURE OF REPAIR CLERK
71. SIGNATURE OF REINFORCEMENT CLERK
72. SIGNATURE OF REWORK CLERK
73. SIGNATURE OF REUSE CLERK
74. SIGNATURE OF REPAIR CLERK
75. SIGNATURE OF REINFORCEMENT CLERK
76. SIGNATURE OF REWORK CLERK
77. SIGNATURE OF REUSE CLERK
78. SIGNATURE OF REPAIR CLERK
79. SIGNATURE OF REINFORCEMENT CLERK
80. SIGNATURE OF REWORK CLERK
81. SIGNATURE OF REUSE CLERK
82. SIGNATURE OF REPAIR CLERK
83. SIGNATURE OF REINFORCEMENT CLERK
84. SIGNATURE OF REWORK CLERK
85. SIGNATURE OF REUSE CLERK
86. SIGNATURE OF REPAIR CLERK
87. SIGNATURE OF REINFORCEMENT CLERK
88. SIGNATURE OF REWORK CLERK
89. SIGNATURE OF REUSE CLERK
90. SIGNATURE OF REPAIR CLERK
91. SIGNATURE OF REINFORCEMENT CLERK
92. SIGNATURE OF REWORK CLERK
93. SIGNATURE OF REUSE CLERK
94. SIGNATURE OF REPAIR CLERK
95. SIGNATURE OF REINFORCEMENT CLERK
96. SIGNATURE OF REWORK CLERK
97. SIGNATURE OF REUSE CLERK
98. SIGNATURE OF REPAIR CLERK
99. SIGNATURE OF REINFORCEMENT CLERK
100. SIGNATURE OF REWORK CLERK

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13244 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>AACU</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b <i>53 Larkin St.</i>		10. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>53 Larkin St.</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A.A. Gen. Hospital</i>		d. STREET ADDRESS <i>Annapolis - Maryland.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William</i> First <i>Butler</i> Last	4. DATE OF DEATH Month <i>12</i> Day <i>5</i> Year <i>1958</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-8-1888</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Thomas Butler</i>		14. MOTHER'S MAIDEN NAME <i>Mary Butler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>yes</i>		16. SOCIAL SECURITY NO. <i>213-18-0892</i>	
17. INFORMANT <i>Lillian McHowan</i>		Address <i>31 College Ct. Service</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac disease</i> <i>434.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. Linhart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhart H.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>12-5-58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-9-1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Reese #108 Wash. St.</i>		ADDRESS <i>Anna Md.</i>	
24a. REC'D BY REGISTRAR <i>DEC 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thrash</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

1. Name of Deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Place of Death: _____

10. Cause of Death: _____

11. Manner of Death: ☐ Natural ☐ Accidental ☐ Suicidal ☐ Homicidal ☐ Undetermined

12. Signature of Medical Examiner: _____

13. Signature of Coroner: _____

14. Signature of Registrar: _____

15. Signature of Physician: _____

16. Signature of Family: _____

17. Signature of Other: _____

18. Signature of Other: _____

19. Signature of Other: _____

20. Signature of Other: _____

21. Signature of Other: _____

22. Signature of Other: _____

23. Signature of Other: _____

24. Signature of Other: _____

25. Signature of Other: _____

26. Signature of Other: _____

27. Signature of Other: _____

28. Signature of Other: _____

29. Signature of Other: _____

30. Signature of Other: _____

31. Signature of Other: _____

32. Signature of Other: _____

33. Signature of Other: _____

34. Signature of Other: _____

35. Signature of Other: _____

36. Signature of Other: _____

37. Signature of Other: _____

38. Signature of Other: _____

39. Signature of Other: _____

40. Signature of Other: _____

41. Signature of Other: _____

42. Signature of Other: _____

43. Signature of Other: _____

44. Signature of Other: _____

45. Signature of Other: _____

46. Signature of Other: _____

47. Signature of Other: _____

48. Signature of Other: _____

49. Signature of Other: _____

50. Signature of Other: _____

51. Signature of Other: _____

52. Signature of Other: _____

53. Signature of Other: _____

54. Signature of Other: _____

55. Signature of Other: _____

56. Signature of Other: _____

57. Signature of Other: _____

58. Signature of Other: _____

59. Signature of Other: _____

60. Signature of Other: _____

61. Signature of Other: _____

62. Signature of Other: _____

63. Signature of Other: _____

64. Signature of Other: _____

65. Signature of Other: _____

66. Signature of Other: _____

67. Signature of Other: _____

68. Signature of Other: _____

69. Signature of Other: _____

70. Signature of Other: _____

71. Signature of Other: _____

72. Signature of Other: _____

73. Signature of Other: _____

74. Signature of Other: _____

75. Signature of Other: _____

76. Signature of Other: _____

77. Signature of Other: _____

78. Signature of Other: _____

79. Signature of Other: _____

80. Signature of Other: _____

81. Signature of Other: _____

82. Signature of Other: _____

83. Signature of Other: _____

84. Signature of Other: _____

85. Signature of Other: _____

86. Signature of Other: _____

87. Signature of Other: _____

88. Signature of Other: _____

89. Signature of Other: _____

90. Signature of Other: _____

91. Signature of Other: _____

92. Signature of Other: _____

93. Signature of Other: _____

94. Signature of Other: _____

95. Signature of Other: _____

96. Signature of Other: _____

97. Signature of Other: _____

98. Signature of Other: _____

99. Signature of Other: _____

100. Signature of Other: _____

13245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Evergreen Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>63 ANNE ARUNDEL GEN. Hosp</u>		e. STREET ADDRESS <u>Grambrills</u>	
3. NAME OF DECEASED (Type or print) <u>MATTHEW</u> First <u>CADDE</u> Middle <u>CADDE</u> Last		4. DATE OF DEATH <u>12</u> Month <u>27</u> Day <u>1958</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>?</u> <u>18</u> <u>84</u> <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>ALABAMA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Anthony Cadde</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE WALKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Catie Rebin Grambrills</u>		Address <u>Grambrills</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> <u>Coronary Arterio Sclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arterio Sclerosis</u> DUE TO (c) <u>Coronary Arterio Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-5-58</u> , 19 <u>58</u> , to <u>12-27-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-5-58</u> , 19 <u>58</u> , and that death occurred at <u>10</u> <u>AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.T. ALLEN</u>		ADDRESS (Street, city or town, state) <u>Grambrills</u> DATE SIGNED <u>12-24-58</u>	
PHYSICIAN'S NAME (Type) <u>A.T. ALLEN</u>		M.D. <u>G.L. Edwards</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-29-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer-Hill</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES E. HICKS</u>		ADDRESS <u>ANNAPOLIS - MD.</u>	
24a. REC'D BY REGISTRAR <u>JAN 27 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knapp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13277 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13246

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Alco</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Herald Harbor.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Herald Harbor - Cranswick</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Valentine Rd. Herald Harbor</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Jack</i> First Middle Last <i>Chavis</i>		4. DATE OF DEATH Month <i>12</i> Day <i>4</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-17-52</i>
9. AGE (In years last birthday) <i>6</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>School</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jack C. Chavis, Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Savalick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-----</i>	
17. INFORMANT <i>Jack C. Chavis, Sr., Same as 2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple injuries</i> <i>812X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Struck by school bus</i>	
20c. TIME OF INJURY Month, Day, Year <i>4:20 p.m. 12-4-58</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>	20f. (City or town) (County) (State) <i>Alco MD</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Hault</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. L. Hault</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/7/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial</i>
22d. LOCATION (City, town, or county) (State) <i>Glen Burnie, Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>James E. Hault</i>		24a. REC'D BY REGISTRAR <i>DEC 8 58</i>	24b. REGISTRAR'S SIGNATURE <i>Charles L. Hault</i>
24c. ADDRESS <i>Hopping and Kirkley, Glen Burnie</i>		DATE <i>12-4-58</i>	

MEDICAL CERTIFICATION

FOR STATE
RECORDS

MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18
1917 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

John C. O'Neil, Sr.
1100 North Broadway
John C. O'Neil, Sr., 1100 North Broadway

1. Name of deceased: John C. O'Neil, Sr.
2. Age: 65 years
3. Sex: Male
4. Race: White
5. Date of death: 1917
6. Place of death: 1100 North Broadway
7. Cause of death: ...
8. Signature of medical examiner: ...
9. Signature of coroner: ...
10. Signature of registrar: ...

13278 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft Meade</u>				c. LENGTH OF STAY IN 1b <u>5 hrs 53 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G. Meade</u>			
				d. STREET ADDRESS <u>Orts 1554-C</u>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>CHRISTMAN</u> Last <u>CHRISTMAN</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>2</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 Dec 1958</u>		9. AGE (In years last birthday) yrs. <u>5</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>53</u>	IF UNDER 24 HRS. Hours <u>53</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles W. Christman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Bourke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Med Records U.S. Army Hosp, Ft Meade, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1 December, 1958</u> , to <u>2 December, 19 58</u> , that I last saw the deceased alive on <u>2 December, 1958</u> , and that death occurred at <u>0323A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Army Hospital, Ft Meade, Md</u> DATE SIGNED <u>2 Dec 58</u>							
ACTUAL SIGNATURE <u>Carl A. Fischer</u> M.D.				U.S. Army Hospital, Ft Meade, Md			
PHYSICIAN'S NAME (Type) <u>CARL A FISCHER, Lt Col, MC</u>				U.S. Army Hospital, Ft Meade, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				ADDRESS <u>1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>DEC 8 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

2050251XV0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13246 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A-A- MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY A-A	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 1 yr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anna Arnold Ben Hosp		d. STREET ADDRESS Sherwood Forest	
3. NAME OF DECEASED (Type or print) First Joseph Middle Spencer Last Clark		4. DATE OF DEATH Month 12 Day 4 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1882
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cauler		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James A. Clark		14. MOTHER'S MAIDEN NAME Harriett Hindes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Anna Gary Clark		Address Sherwood Forest, A.A.Co. Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema Bronchial Asthma + Cor pulmonale			INTERVAL BETWEEN ONSET AND DEATH Minutes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour 6.11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Nov 29, 1958 to Dec 4, 1958 , that I last saw the deceased alive on Dec 3, 1958 , and that death occurred at 9 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard N. Peeler		DATE SIGNED 12/4/58	
PHYSICIAN'S NAME (Type) RICHARD N. PEELER		ANNAPOLIS, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 6, 1958	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) Baltimore, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.		ADDRESS 1900 Eutaw Place	
24a. REC'D BY REGISTRAR DEC 8 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13247

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>54 State Circle</u>		d. STREET ADDRESS <u>54 State Circle</u>	
3. NAME OF DECEASED (Type or print) <u>Annie Corcoran Clayton</u>		4. DATE OF DEATH <u>12-22-1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 26th 1867</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Harwood Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard Clayton</u>		14. MOTHER'S MAIDEN NAME <u>Helen Ash</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Thos C. Griffin</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Broncho-Pneumonia (Terminal)</u> DUE TO (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 19, 1958</u> , to <u>Dec 22, 1958</u> , that I last saw the deceased alive on <u>Dec 22, 1958</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert L. Anderson</u>		ADDRESS (Street, city or town, state) <u>44 Southgate Ave., Annapolis, Md</u>	
PHYSICIAN'S NAME (Type) <u>Albert L. Anderson, M.D.</u>		DATE <u>12/22/58</u>	
22a. BURIAL, CREMATION, REMOVAL, SPECIFIC <u>Burial</u>		22b. DATE THEREOF <u>12-24-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cent</u>		22d. LOCATION (City, town, or county) (State) <u>Owensville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Surr</u>		ADDRESS <u>Annapolis Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Krause</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13248 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>				d. STREET ADDRESS <u>10 Nicks Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CONROLTON</u> Middle <u>COLBERT</u> Last <u>COLBERT</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>12</u> Year <u>1958</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-58</u>	9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min. <u>20</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Calvin Colbert</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Galloway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Calvin Colbert</u> Address <u>10 Nicks Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATITIS, ACUTE</u> <u>773.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11 DEC</u> , 19 <u>58</u> , to <u>12 DEC</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12 DEC</u> , 19 <u>58</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stuart Walker MD</u> M.D.				ADDRESS (Street, city or town, state) <u>141 Cathedral St, Annapolis, Md.</u>		DATE SIGNED <u>13 Dec 58</u>	
PHYSICIAN'S NAME (Type) <u>Stuart Walker MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Broad Neck</u>		22d. LOCATION (City, town, or county) (State) <u>Skidmore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Seese Jr.</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

4000215XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1255

CERTIFICATE OF DEATH

REG. NO. 100

1. NAME OF DECEASED JOHN J. SMITH		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 10/15/1905		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION Carpenter		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF DEATH Home		10. DATE OF DEATH 11/10/1950	
11. SIGNATURE OF PHYSICIAN J. H. BROWN		12. SIGNATURE OF REGISTRAR A. J. SMITH		13. SIGNATURE OF WITNESS J. H. BROWN		14. SIGNATURE OF WITNESS A. J. SMITH		15. SIGNATURE OF WITNESS J. H. BROWN	
16. SIGNATURE OF WITNESS A. J. SMITH		17. SIGNATURE OF WITNESS J. H. BROWN		18. SIGNATURE OF WITNESS A. J. SMITH		19. SIGNATURE OF WITNESS J. H. BROWN		20. SIGNATURE OF WITNESS A. J. SMITH	
21. SIGNATURE OF WITNESS J. H. BROWN		22. SIGNATURE OF WITNESS A. J. SMITH		23. SIGNATURE OF WITNESS J. H. BROWN		24. SIGNATURE OF WITNESS A. J. SMITH		25. SIGNATURE OF WITNESS J. H. BROWN	
26. SIGNATURE OF WITNESS A. J. SMITH		27. SIGNATURE OF WITNESS J. H. BROWN		28. SIGNATURE OF WITNESS A. J. SMITH		29. SIGNATURE OF WITNESS J. H. BROWN		30. SIGNATURE OF WITNESS A. J. SMITH	
31. SIGNATURE OF WITNESS J. H. BROWN		32. SIGNATURE OF WITNESS A. J. SMITH		33. SIGNATURE OF WITNESS J. H. BROWN		34. SIGNATURE OF WITNESS A. J. SMITH		35. SIGNATURE OF WITNESS J. H. BROWN	
36. SIGNATURE OF WITNESS A. J. SMITH		37. SIGNATURE OF WITNESS J. H. BROWN		38. SIGNATURE OF WITNESS A. J. SMITH		39. SIGNATURE OF WITNESS J. H. BROWN		40. SIGNATURE OF WITNESS A. J. SMITH	
41. SIGNATURE OF WITNESS J. H. BROWN		42. SIGNATURE OF WITNESS A. J. SMITH		43. SIGNATURE OF WITNESS J. H. BROWN		44. SIGNATURE OF WITNESS A. J. SMITH		45. SIGNATURE OF WITNESS J. H. BROWN	
46. SIGNATURE OF WITNESS A. J. SMITH		47. SIGNATURE OF WITNESS J. H. BROWN		48. SIGNATURE OF WITNESS A. J. SMITH		49. SIGNATURE OF WITNESS J. H. BROWN		50. SIGNATURE OF WITNESS A. J. SMITH	
51. SIGNATURE OF WITNESS J. H. BROWN		52. SIGNATURE OF WITNESS A. J. SMITH		53. SIGNATURE OF WITNESS J. H. BROWN		54. SIGNATURE OF WITNESS A. J. SMITH		55. SIGNATURE OF WITNESS J. H. BROWN	
56. SIGNATURE OF WITNESS A. J. SMITH		57. SIGNATURE OF WITNESS J. H. BROWN		58. SIGNATURE OF WITNESS A. J. SMITH		59. SIGNATURE OF WITNESS J. H. BROWN		60. SIGNATURE OF WITNESS A. J. SMITH	
61. SIGNATURE OF WITNESS J. H. BROWN		62. SIGNATURE OF WITNESS A. J. SMITH		63. SIGNATURE OF WITNESS J. H. BROWN		64. SIGNATURE OF WITNESS A. J. SMITH		65. SIGNATURE OF WITNESS J. H. BROWN	
66. SIGNATURE OF WITNESS A. J. SMITH		67. SIGNATURE OF WITNESS J. H. BROWN		68. SIGNATURE OF WITNESS A. J. SMITH		69. SIGNATURE OF WITNESS J. H. BROWN		70. SIGNATURE OF WITNESS A. J. SMITH	
71. SIGNATURE OF WITNESS J. H. BROWN		72. SIGNATURE OF WITNESS A. J. SMITH		73. SIGNATURE OF WITNESS J. H. BROWN		74. SIGNATURE OF WITNESS A. J. SMITH		75. SIGNATURE OF WITNESS J. H. BROWN	
76. SIGNATURE OF WITNESS A. J. SMITH		77. SIGNATURE OF WITNESS J. H. BROWN		78. SIGNATURE OF WITNESS A. J. SMITH		79. SIGNATURE OF WITNESS J. H. BROWN		80. SIGNATURE OF WITNESS A. J. SMITH	
81. SIGNATURE OF WITNESS J. H. BROWN		82. SIGNATURE OF WITNESS A. J. SMITH		83. SIGNATURE OF WITNESS J. H. BROWN		84. SIGNATURE OF WITNESS A. J. SMITH		85. SIGNATURE OF WITNESS J. H. BROWN	
86. SIGNATURE OF WITNESS A. J. SMITH		87. SIGNATURE OF WITNESS J. H. BROWN		88. SIGNATURE OF WITNESS A. J. SMITH		89. SIGNATURE OF WITNESS J. H. BROWN		90. SIGNATURE OF WITNESS A. J. SMITH	
91. SIGNATURE OF WITNESS J. H. BROWN		92. SIGNATURE OF WITNESS A. J. SMITH		93. SIGNATURE OF WITNESS J. H. BROWN		94. SIGNATURE OF WITNESS A. J. SMITH		95. SIGNATURE OF WITNESS J. H. BROWN	
96. SIGNATURE OF WITNESS A. J. SMITH		97. SIGNATURE OF WITNESS J. H. BROWN		98. SIGNATURE OF WITNESS A. J. SMITH		99. SIGNATURE OF WITNESS J. H. BROWN		100. SIGNATURE OF WITNESS A. J. SMITH	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13251

13249 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>5 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Adehaid</u> Middle <u>Gross</u> Last <u>Dorsey</u>		4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-99</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>	IF UNDER 24 HRS. Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>ANNA.</u>	
13. FATHER'S NAME <u>WILLIAM T. Gross</u>		14. MOTHER'S MAIDEN NAME <u>SERENA MILLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>James Dorsey-96 Clay St. ANNA.</u>	
17. INFORMANT <u>James Dorsey-96 Clay St. ANNA.</u>		Address <u>ANNA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Insufficiency</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pyelonephritis (chronic)</u> DUE TO (c) <u>Pyelonephritis (chronic)</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 19</u> , 1958, to <u>Dec 20</u> , 1958, that I last saw the deceased alive on <u>Dec 20</u> , 1958, and that death occurred at <u>7:10 P.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, MD.</u>	
ACTUAL SIGNATURE <u>Ch. Richardson</u>		DATE SIGNED <u>12/20/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-23-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BREWER HILL</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u>		ADDRESS <u>ANNA, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 29 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13252

13279

Items 8,9 Film 257 1-5-59 et
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 17y 5m 26d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 536 Dolphin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Zippora Dorsey		4. DATE OF DEATH Month Day Year 12 26 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1892? 1900 9. AGE (In years last birthday) 66 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Palmer		14. MOTHER'S MAIDEN NAME Leah Finney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Cardio-vascular Disease DUE TO (c) Syphilis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 12/26 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 12/26 19 58	
21. I certify that I attended the deceased from 6/30 , 19 41 , to 12/26 , 19 58 , that I last saw the deceased alive on 12/26 , 19 58 , and that death occurred at 9:00 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 12/29/58	
ACTUAL SIGNATURE Lionel McHenry Mapp, M. D.		PHYSICIAN'S NAME (Type) Crownsville State Hospital, Md. 12/29/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		22d. LOCATION (City, town, or county) (State) Ann Arundel County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Halstead		ADDRESS 918 Druid Hill Ave	
24a. REC'D BY REGISTRAR JAN 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

1927

DEPARTMENT OF HEALTH

<p>1. Name of deceased (Print name and surname) _____</p>		<p>2. Sex _____</p>		<p>3. Age (Years) _____</p>	
<p>4. Date of death _____</p>		<p>5. Time of death _____</p>		<p>6. Place of death _____</p>	
<p>7. Cause of death (State immediately and briefly) _____</p>		<p>8. Nature of disease (State fully) _____</p>		<p>9. Duration of disease (State fully) _____</p>	
<p>10. Name of attending physician _____</p>		<p>11. Name of medical examiner _____</p>		<p>12. Name of coroner _____</p>	
<p>13. Name of registrar _____</p>		<p>14. Name of funeral director _____</p>		<p>15. Name of undertaker _____</p>	
<p>16. Name of cemetery _____</p>		<p>17. Name of lot _____</p>		<p>18. Name of monument _____</p>	
<p>19. Name of interment _____</p>		<p>20. Name of burial _____</p>		<p>21. Name of cremation _____</p>	
<p>22. Name of crematorium _____</p>		<p>23. Name of cremation _____</p>		<p>24. Name of cremation _____</p>	
<p>25. Name of cremation _____</p>		<p>26. Name of cremation _____</p>		<p>27. Name of cremation _____</p>	
<p>28. Name of cremation _____</p>		<p>29. Name of cremation _____</p>		<p>30. Name of cremation _____</p>	
<p>31. Name of cremation _____</p>		<p>32. Name of cremation _____</p>		<p>33. Name of cremation _____</p>	
<p>34. Name of cremation _____</p>		<p>35. Name of cremation _____</p>		<p>36. Name of cremation _____</p>	
<p>37. Name of cremation _____</p>		<p>38. Name of cremation _____</p>		<p>39. Name of cremation _____</p>	
<p>40. Name of cremation _____</p>		<p>41. Name of cremation _____</p>		<p>42. Name of cremation _____</p>	
<p>43. Name of cremation _____</p>		<p>44. Name of cremation _____</p>		<p>45. Name of cremation _____</p>	
<p>46. Name of cremation _____</p>		<p>47. Name of cremation _____</p>		<p>48. Name of cremation _____</p>	
<p>49. Name of cremation _____</p>		<p>50. Name of cremation _____</p>		<p>51. Name of cremation _____</p>	
<p>52. Name of cremation _____</p>		<p>53. Name of cremation _____</p>		<p>54. Name of cremation _____</p>	
<p>55. Name of cremation _____</p>		<p>56. Name of cremation _____</p>		<p>57. Name of cremation _____</p>	
<p>58. Name of cremation _____</p>		<p>59. Name of cremation _____</p>		<p>60. Name of cremation _____</p>	
<p>61. Name of cremation _____</p>		<p>62. Name of cremation _____</p>		<p>63. Name of cremation _____</p>	
<p>64. Name of cremation _____</p>		<p>65. Name of cremation _____</p>		<p>66. Name of cremation _____</p>	
<p>67. Name of cremation _____</p>		<p>68. Name of cremation _____</p>		<p>69. Name of cremation _____</p>	
<p>70. Name of cremation _____</p>		<p>71. Name of cremation _____</p>		<p>72. Name of cremation _____</p>	
<p>73. Name of cremation _____</p>		<p>74. Name of cremation _____</p>		<p>75. Name of cremation _____</p>	
<p>76. Name of cremation _____</p>		<p>77. Name of cremation _____</p>		<p>78. Name of cremation _____</p>	
<p>79. Name of cremation _____</p>		<p>80. Name of cremation _____</p>		<p>81. Name of cremation _____</p>	
<p>82. Name of cremation _____</p>		<p>83. Name of cremation _____</p>		<p>84. Name of cremation _____</p>	
<p>85. Name of cremation _____</p>		<p>86. Name of cremation _____</p>		<p>87. Name of cremation _____</p>	
<p>88. Name of cremation _____</p>		<p>89. Name of cremation _____</p>		<p>90. Name of cremation _____</p>	
<p>91. Name of cremation _____</p>		<p>92. Name of cremation _____</p>		<p>93. Name of cremation _____</p>	
<p>94. Name of cremation _____</p>		<p>95. Name of cremation _____</p>		<p>96. Name of cremation _____</p>	
<p>97. Name of cremation _____</p>		<p>98. Name of cremation _____</p>		<p>99. Name of cremation _____</p>	
<p>100. Name of cremation _____</p>		<p>101. Name of cremation _____</p>		<p>102. Name of cremation _____</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13280 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater		c. LENGTH OF STAY IN 1b 10 MO X Edgewater	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS RT 2 Box 76 B	
3. NAME OF DECEASED (Type or print) CATHERINE MARIE DOVE		4. DATE OF DEATH 12 27 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/55
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Annapolis Md.	
11. BIRTHPLACE (State or foreign, country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wilson Howard Dove		14. MOTHER'S MAIDEN NAME Hilda Marie Ireland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hilda M Dove Edgewater Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 344X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 344X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Peetz M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/28/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/58	
22c. NAME OF CEMETERY OR CREMATORY MT Zion		22d. LOCATION (City, town, or county) (State) Lothian Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Barney Hardaway ADDRESS Beltsville Md.		24a. REC'D BY REGISTRAR DAIAN 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kians			

2063273XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 22 Film G237 12-31-58 et

18

13281

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13254

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 20 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James First Middle Farrell^{1st}		4. DATE OF DEATH 12th 19th 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Allen Farrell		14. MOTHER'S MAIDEN NAME Lucy Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or date of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Lucy Farrell, Duaghter, Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 023x DUE TO Syphilitic and arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. ----- 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-13-1938 , 19 58 , to 12-13- 19 58 , that I last saw the deceased alive on 12-13- 19 58 , and that death occurred at 2.25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Benedict, M. D.		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 12/13/58	
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		ADDRESS Crownsville State Hospital, Md. DATE SIGNED 12/13/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF ??	
22c. NAME OF CEMETERY OR CREMATORY "Hospital Grounds"		22d. LOCATION (City, town, or county) (State) Crownsville, A. A. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kiser		ADDRESS -----	
24a. REC'D BY REGISTRAR DEC 22 '58		24b. REGISTRAR'S SIGNATURE Charles E. Kiser	

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BALTIMORE 16

1923

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES A. [illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	
DATE OF INTERMENT		TIME OF INTERMENT		PLACE OF INTERMENT		CAUSE OF INTERMENT		MANNER OF INTERMENT		SIGNATURE OF MINISTER	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	
DATE OF BURIAL		TIME OF BURIAL		PLACE OF BURIAL		CAUSE OF BURIAL		MANNER OF BURIAL		SIGNATURE OF MINISTER	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	

[Handwritten signature]

13282 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Queen Anne's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived: If institution, residence before admission) o. STATE <i>College Park MD (2606)</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mallersville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>8902 TRADE ISLAND AVE - 1614-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sara Harrington - Mallersville Md</i>		d. STREET ADDRESS <i>Mallersville Md</i>	
3. NAME OF DECEASED (Type or print) <i>Emmy Frances Lindner</i>		4. DATE OF DEATH <i>Dec 25 - 1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 9 - 1897</i>
9. AGE (In years lost birthday) <i>101</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Mallersville Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>ROBERT W. BEVIN</i>		14. MOTHER'S MAIDEN NAME <i>ELIZABETH KING</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>MARY E. HARDY</i>		Address <i>College Park, Md. 4809 Osage St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cycle Pulmonary Edema.</i> 490x DUE TO <i>Lobar Pneumonia.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Senescence (101 years).</i> (c) <i>Senescence (101 years).</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days 2 weeks.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April 8, 1958</i> to <i>Dec 25, 58</i> , that I last saw the deceased alive on <i>Dec 25, 58</i> , and that death occurred at <i>8:10 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. Joseph Lipskey</i>		DATE SIGNED <i>12-26-58</i>	
PHYSICIAN'S NAME (Type) <i>DR. JOSEPH LIPSKEY</i>		ADDRESS <i>Odenton, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/27/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>WOODLAWN Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>BALTIMORE, MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. CHAMBERS Co - Riverdale, Md.</i>		24a. REC'D BY REGISTRAR <i>DA DEC 30 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13283 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13256

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Odenton</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 yrs</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Odenton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>				d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Rosa</u> First <u>Ellis</u> Middle <u>Gaskins</u> Last			4. DATE OF DEATH Month <u>Dec</u> Day <u>2</u> Year <u>1958</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Neg</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Feb 22 1874</u>		9. AGE (in years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13. FATHER'S NAME <u>James Henderson</u>			
14. MOTHER'S MAIDEN NAME <u>Elisa Chisley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>220-078824</u>		17. INFORMANT <u>Mary E. Gaskins</u> Address <u>Odenton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction (Coronary artery disease)</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Congestive Heart Failure 2 yrs</u> (a), stating the underlying cause last. (c) <u>Arteriosclerotic Heart Disease 1/2 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> o. m. <u>19</u> p. m.			
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>D. Henry G. Wise, Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/2/58</u>	
EXAMINER'S NAME (Type) <u>Henry A. Wise, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Dec. 7/1958</u>		22b. DATE THEREOF <u>Dec. 7/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>	
22d. LOCATION (City, town, or county) (State) <u>Odenton</u> <u>Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Johnson</u>		24a. REC'D BY REGISTRAR <u>DEC 8 58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>William S. Harris</u>					

1938

STATE OF MARYLAND

1938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

DEPT. OF HEALTH
Baltimore

1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Death: Jan 15, 1938

5. Place of Death: Home

6. Cause of Death: Heart Disease

7. Manner of Death: Natural

8. Signature of Medical Examiner: John Doe

9. Signature of Coroner: John Doe

10. Signature of Registrar: John Doe

11. Signature of Burial Officer: John Doe

12. Signature of Undertaker: John Doe

13. Signature of Funeral Home: John Doe

14. Signature of Cemetery: John Doe

15. Signature of Burial: John Doe

16. Signature of Interment: John Doe

17. Signature of Burial: John Doe

18. Signature of Interment: John Doe

19. Signature of Burial: John Doe

20. Signature of Interment: John Doe

13284 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>				c. LENGTH OF STAY IN 1b <u>3/Mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 275 Brightwood Ave</u>				/d. STREET ADDRESS <u>Box. 275 Brightwood Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Gottlieb</u>				4. DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 14, 1877</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Santation Worker (Ret)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown Gotteib</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>M Mrs. Edward Gotteib, 2301 Smith Ave. Balto. 27. Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>490x Global Pneumonia - Pneumonitis</u> DUE TO <u>Septicemia -</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Viral Infection to Urinary Tract Infection -</u> DUE TO <u> </u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardio Vascular Disease -</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks -</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>10-5</u> , 19 <u>58</u> , to <u>12-13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-13</u> , 19 <u>58</u> , and that death occurred at <u>2 4</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Febus Gauberg</u>				ADDRESS (Street, city or town, state) <u>P. Box 37 - (Odenton Md)</u>		DATE SIGNED <u>12/15-58</u>	
PHYSICIAN'S NAME (Type) <u>Febus Gauberg</u>				M.D. <u> </u>		M.D. <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 18, 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn, R.F.D. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. S. Slaughter</u>				ADDRESS <u>Glen Burnie, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 18 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				24c. REGISTRAR'S SIGNATURE <u> </u>		24d. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF MOTOR VEHICLES

— — — — —

13285

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>WALLER</u> Last <u>Greenwell</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Empl'd. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant-Tavern</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>William Clayton Greenwell</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Howard</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W. I</u>	
16. SOCIAL SECURITY NO. <u>W.W. I</u>		17. INFORMANT <u>Edna King Greenwell</u> Address <u>--Bristol, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery disease</u> DUE TO <u>Obesity</u> (c) <u>Obesity</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unk</u> <u>7 yrs</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1948</u> to <u>Dec 22, 1958</u> , that I last saw the deceased alive on <u>21 Dec</u> , 1958, and that death occurred at <u>4:05</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R B Sasscer</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Upper Marlboro Md 12/22/58</u>	
PHYSICIAN'S NAME (Type) <u>Robert B. Sasscer,</u> M.D.		<u>Upper Marlboro, Md.</u> <u>12/22/58:</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Funeral Home-boro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 30 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13250 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mill Creek</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. General Hospit</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>LEATHA</u> Last <u>GUNTHER</u>		4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-1891</u>
9. AGE (In years last birthday) yrs. <u>67</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Martinsburg W Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>William H. Gunther</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO (c) <u>UNKNOWN</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 Hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/14</u> , 19 <u>58</u> , to <u>12/14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>58</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>4 Suttergate Ave</u> DATE SIGNED <u>12/15/58</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-17-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Urlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Urlington Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>U.S. Annapolis Md</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

41 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

63

1

0

13286

CERTIFICATE OF DEATH

13260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>ANN ARUNDEL</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Gambrell's</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Box 81, Gambrell's P.O. MD</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Gambrell's</u>	
f. STREET ADDRESS <u>Box 81, Gambrell's P.O.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>IRVING</u> Last <u>HONOR</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 17, 1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Detroit Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Briley Honor</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN ANDERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-10-5493</u>	
17. INFORMANT <u>PAUL I. HONOR JR.</u>		Address <u>Box 81, Gambrell's P.O. MD</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>4341</u> DUE TO <u>Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>-</u> p. m. <u>-</u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/12/50</u> to <u>12/24/58</u> , that I last saw the deceased alive on <u>12/24/58</u> , and that death occurred at <u>11:05 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. W. Richardson</u>		DATE SIGNED <u>12/27/58</u>	
PHYSICIAN'S NAME (Type) <u>R. W. RICHARD MD</u>		ADDRESS (Street, city or town, state) <u>715 Cotter Rd Glen Burnie, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Dec. 29-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore City MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singletary</u>		ADDRESS <u>John Burnie</u>	
24a. REC'D BY REGISTRAR <u>DATE 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. HARRIS		Male		45		1880		Maryland		Farmer		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. DISEASE OR INJURY		14. PERIOD OF ILLNESS		15. PRESENTING SYMPTOMS		16. TREATMENT	
April 15, 1920		10:30 AM		Home		Heart Failure		Coronary Artery Disease		2 weeks		Chest pain, shortness of breath		Medicine, rest	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF DECEASED		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF MINISTER		22. SIGNATURE OF CLERK		23. SIGNATURE OF JUDGE		24. SIGNATURE OF SHERIFF	
J. H. Harris		J. H. Harris, J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

FILE IN CLERK'S OFFICE

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE CLERK TO SEE THAT IT IS CORRECTLY FILED AND THAT IT IS NOT LOST OR DESTROYED. THE CLERK IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

13287

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 13, Film G-238 1/28/59.cae

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

AA

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

DEALE

c. LENGTH OF STAY IN 1b

64 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE MD

b. COUNTY AA

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X CHURCHTON

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

1 STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)First Middle Last
HERBERT FRANKLIN HOWES4. DATE
OF
DEATHMonth Day Year
DEC 25 1958

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

7/20/94

9. AGE (In years
last birthday)

64 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

WATERMAN

10b. KIND OF BUSINESS OR INDUSTRY

Seafood

11. BIRTHPLACE (State or foreign country)

Churchton

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

NANNY/1/4/18/Robert F. Howes

14. MOTHER'S MAIDEN NAME

VIRGIE U. Trott

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

- -

16. SOCIAL SECURITY NO.

17. INFORMANT

JOSHUA T.

Address

CHURCHTON DEALE, MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

850X

DUE TO

DROWNING

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

APPARENTLY FELL OVERBOARD - Wards Boat Yard

20c. TIME OF INJURY

Month, Day, Year

Hour a. m. p. m.

12/25 1958

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Boat Yard

20f. (City or town)

AA. Co - Deale

(County)

MD

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Russell S. Fisher

M.D.

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☐

12/26/58

EXAMINER'S
NAME (Type)

Russell S. Fisher

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

12/28/58

22c. NAME OF CEMETERY OR CREMATORY

Friendship Md.

22d. LOCATION (City, town, or county)

Friendship Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Russell S. Fisher

ADDRESS

24a. REC'D BY REGISTRAR

DATE JAN 2 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Kane

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 8y 2m d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Baltimore d. STREET ADDRESS 505 West Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry First Shelton Middle Jobbs Last		4. DATE OF DEATH Month 12 Day 16 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/91
9. AGE (In years last birthday) yrs. 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Jobbs		14. MOTHER'S MAIDEN NAME Mary Hayward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - Hypostatic DUE TO (b) Cerebral Thrombosis with Quadriplegia DUE TO (c) Cerebral & Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus Ulcers, old burn on fingers of right hand		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) -----	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/16 19 50 to 12/16 19 58 , that I last saw the deceased alive on 12/16 19 58 , and that death occurred at 2:00A. M, from the causes and on the date stated above.	
ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.	ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 12/16/58
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.	Crownsville State Hospital, Md. 12/16/58

22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12/14/58	22c. NAME OF CEMETERY OR CREMATORY U. S. of M. C.	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. R. R. II		ADDRESS Annapolis Md.	24a. REC'D BY REGISTRAR DEC 24 '58
		24b. REGISTRAR'S SIGNATURE Arthur S. R. R.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>	
<p>4. Date of death: <u>Jan 15, 1950</u></p>	
<p>5. Place of death: <u>Home</u></p>	
<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Signature of physician: <u>Dr. J. Smith</u></p>	
<p>8. Signature of registrar: <u>John Doe</u></p>	
<p>9. Date of registration: <u>Jan 16, 1950</u></p>	
<p>10. Place of registration: <u>Baltimore</u></p>	
<p>11. Name of informant: <u>John Doe</u></p>	
<p>12. Address of informant: <u>123 Main St.</u></p>	
<p>13. City: <u>Baltimore</u></p>	
<p>14. State: <u>Md.</u></p>	
<p>15. Zip: <u>21201</u></p>	
<p>16. Date of birth: <u>Jan 1, 1905</u></p>	
<p>17. Date of death: <u>Jan 15, 1950</u></p>	
<p>18. Date of registration: <u>Jan 16, 1950</u></p>	
<p>19. Date of filing: <u>Jan 17, 1950</u></p>	
<p>20. Date of issue: <u>Jan 18, 1950</u></p>	

13251 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA - MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY A-A -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Gen - Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clarence Middle Johnson Last Johnson				4. DATE OF DEATH Month 12 Day 23 Year 1958			
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-1895	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63	IF UNDER 24 HRS. Days 63 Hours 63 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Academy		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Richard Johnson				14. MOTHER'S MAIDEN NAME Priscilla Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.I.		16. SOCIAL SECURITY NO. W.W.I.		17. INFORMANT Daisy Johnson Address 1830 West St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 16 mo.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. 19 Day. 19 Year. 1957 Hour a. m. 12 p. m. 12				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from Aug , 1957, to 12/23 , 1958, that I last saw the deceased alive on 12/22 , 1958, and that death occurred at 4:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard N. Peeler				ADDRESS (Street, city or town, state) 121 Cathedral St DATE SIGNED 12/23/58			
PHYSICIAN'S NAME (Type) RICHARD N. PEELER				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-58		22c. NAME OF CEMETERY OR CREMATORY Anna Neck		22d. LOCATION (City, town, or county) Annapolis Md. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Beece ADDRESS #108 Wash. St. Annapolis Md.				24a. REC'D BY REGISTRAR DEC 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13289 CERTIFICATE OF DEATH

13264

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>A.A. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> h. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn Park</i>		c. LENGTH OF STAY IN 1b <i>4 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>128 Meadow Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ivan</i> First Middle Last <i>Kavalow</i>		4. DATE OF DEATH <i>December 9</i> Month Day Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/9/1878</i>
9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Poland</i> ✓	
13. FATHER'S NAME <i>Simeon Kavalow</i>		14. MOTHER'S MAIDEN NAME <i>Ekaterina Pimerov</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Leon Kavalow</i> Address <i>82 Collington Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Thrombosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct</i> , 19 <i>55</i> , to <i>Dec</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Dec 9</i> , 19 <i>58</i> , and that death occurred at <i>3:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eugene Schmitzer</i>		ADDRESS (Street, city or town, state) <i>3904 S. Hanover St Baltimore 25, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Eugene Schmitzer, M.D.</i>		DATE SIGNED <i>12-9-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/10/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Nicholas</i>		22d. LOCATION (City, town, or county) (State) <i>Mellville New Jersey</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Fialkowski</i> ADDRESS <i>2007 Eastern Ave</i>		24a. REC'D BY REGISTRAR <i>Wm. J. Fialkowski</i> DATE <i>DEC 11 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Wm. J. Fialkowski</i>			

18222 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

18222

18222

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1877</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 15 1900</i>		9. NAME OF SPOUSE <i>Jane Doe</i>		10. PLACE OF MARRIAGE <i>Baltimore, Md.</i>		11. DATE OF DEATH <i>Jan 15 1922</i>		12. PLACE OF DEATH <i>Baltimore, Md.</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MEDICAL HISTORY <i>None</i>		15. PRESENT ILLNESS <i>None</i>		16. TREATMENT <i>None</i>		17. SIGNATURE OF PHYSICIAN <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF SPOUSE <i>Jane Doe</i>		21. SIGNATURE OF CHILD <i>John Doe</i>		22. SIGNATURE OF PARENT <i>John Doe</i>		23. SIGNATURE OF NEAREST RELATIVE <i>John Doe</i>		24. SIGNATURE OF CLERK <i>John Doe</i>	



30

TO BE FILLED BY THE CLERK OF THE COURT OF COMMON PLEAS, BALTIMORE, MARYLAND.

18222

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13290 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13265
10000

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Arnold</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magothy River 3/4 of a mile from Shore Acres.</u>				/d. STREET ADDRESS <u>Shore Acres Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Wright King</u>				4. DATE OF DEATH Month <u>December</u> Day <u>1st.</u> Year <u>19 58</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>8/29/23</u>		9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homes - Ren.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Walter Scott King</u>			
14. MOTHER'S MAIDEN NAME <u>Irene Wright</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Coast Guard World War II</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT Address <u>Branton King (brother)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>850x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>The boat he was riding submerged.</u>					
20c. TIME OF INJURY Month, Day, Year <u>1.30</u> a. m. <u>11/27/58</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Magothy River</u>			
20f. (City or town) <u>Arnold</u>		(County) <u>A.A.</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/1/58</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-4-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>			
22d. LOCATION (City, town, or county) <u>Glen Burnie</u>		(State) <u>Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			
DATE <u>DEC 4 '58</u>		DATE <u>DEC 4 '58</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13965

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
13800 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.



Form with multiple sections for medical examination and death certification, including checkboxes for various conditions and a large central area for notes.

SECTION 1: GENERAL INFORMATION

SECTION 2: CAUSE OF DEATH

SECTION 3: MANNER OF DEATH

SECTION 4: MEDICAL HISTORY

SECTION 5: PHYSICAL EXAMINATION

SECTION 6: LABORATORY EXAMINATIONS

SECTION 7: SIGNATURES

SECTION 8: NOTES

Vertical text on the right margin, likely a filing or tracking number.

13291 CERTIFICATE OF DEATH

13266

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G. Meade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>		d. STREET ADDRESS <u>5010 Beaufort Ave</u>	
3. NAME OF DECEASED (Type or print) <u>BENEDICT</u> <u>Benedict</u> <u>J.</u> <u>KREINER</u> <u>Kreiner</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>29</u> Year <u>58</u> <u>Dec. 29 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 May 1921</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S.A. Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John C. Kreiner</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Mae Gordon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>213-14-8974</u>	
17. INFORMANT <u>Wife: Betty Kreiner</u>		Address <u>5010 Beaufort Ave, Baltimore, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Candice arrest</u> <u>141.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post operative pneumonia - left</u> DUE TO (c) <u>Carcinoma, lingual</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs.</u> <u>6 1/2 "</u> <u>about 2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>lingual</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>19</u> to <u>29 Dec</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>29 Dec</u> , 19 <u>58</u> , and that death occurred at <u>5:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald M. Etelson, Capt, MC</u> M.D.		ADDRESS (Street, city or town, state) <u>USAH, FGGM, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>DONALD M. ETELSON, Capt, MC, U.S. Army Hospital Ft Meade, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-2-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1247 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>DEC 31 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13292 CERTIFICATE OF DEATH

13267

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Ferndale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 Eugenia Avenue</u>		d. STREET ADDRESS <u>1 Eugenia Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>A.</u> Last <u>KREISSIG</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(ret'd) Funeral Director</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Funeral</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Kreissig</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Schuesse</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-10-2800</u>	
17. INFORMANT <u>Anna Conner, 1 Eugenia Avenue, Ferndale</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>Dec 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>58</u> , and that death occurred at <u>9:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph A. Taler</u>		M.D. <u>102 B & Bld. N.E.</u> DATE SIGNED <u>12-24-58</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH A TALER</u>		<u>Celen Butwine, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-27-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Christina S. Thomas</u>	

13293

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Orchard Beach</u>		LENGTH OF STAY (in this place) <u>10 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Orchard Beach</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1200 Beach Promenade</u>				STREET ADDRESS (If rural give location) <u>1200 Promenade</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>ETHEL</u> (Middle) <u>LILLIAN</u> (Last) <u>Loudenslager</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 31, 1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>July 10, 1901</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BEAUTICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BEAUTY SALON</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE Muench</u>				14. MOTHER'S MAIDEN NAME <u>MARY BRAUN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Jesse Loudenslager Orchard Beach</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Acute Pulmonary Edema</u>				<u>3 weeks</u>			
DUE TO ANTECEDENT CAUSE(S) (B) <u>Coronary Insufficiency</u>				<u>2 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Cardiovascular Disease</u>				<u>2 years</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchial Asthma</u>				<u>5 years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/18</u> , 19 <u>58</u> , to <u>12/31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/24</u> , 19 <u>58</u> , and that death occurred at <u>3:15 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. Brady Smith</u> M.D. <u>Riviera Beach, Md.</u>				DATE SIGNED <u>12/31/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-3-59</u>		NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u>	
24. REC'D BY REGISTRAR DATE <u>JAN 5 '59</u>		REGISTRAR'S SIGNATURE <u>Orlinda E. House</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwing</u> ADDRESS <u>Barbara M. Schwing 2101 Frederick Ave</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

13252 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General Hospt.</i>		d. STREET ADDRESS <i>1113 Main</i>	
3. NAME OF DECEASED (Type or print) First <i>Rosario</i> Middle <i>Maggio</i> Last <i></i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>24</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 19th 1889</i>
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>	
11. BIRTHPLACE (State or foreign country) <i>Lafayette Sicily</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Guisepppe Maggio</i>		14. MOTHER'S MAIDEN NAME <i>Rose Di Stefano</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Rose</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause last. (b) <i>arteriosclerotic C. VD</i> DUE TO (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-19-1956</i> , to <i>12-24-1958</i> , that I last saw the deceased alive on <i>12-3-58</i> , 19 <i>58</i> , and that death occurred at <i>10-40 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M. Shipley</i> M.D.		ADDRESS (Street, city or town, state) <i>121 Cathedral St Annapolis, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Frank M. Shipley</i>		DATE SIGNED <i>12-26-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-27-1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylors</i> ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 29 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13853

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1900</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1925</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>Dec 10 1945</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>16. OFFICIAL SEAL</p>	

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his or her last illness.

2. The cause of death should be stated in as many words as possible, giving the immediate cause, and the remote cause, if known.

3. The date of death should be stated in full, including the day, month, and year.

4. The place of death should be stated in full, including the street, city, county, and state.

5. The signature of the physician or other qualified person should be written in ink, and the official seal should be attached.

6. The signature of the registrar should be written in ink, and the official seal should be attached.

7. This certificate is to be filed in the office of the Registrar of Deaths, and a copy is to be sent to the office of the Health Officer.

13253 CERTIFICATE OF DEATH

13253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 202 S. Southwood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ESSIE		Middle LISSNER		Last MARX		4. DATE OF DEATH Month DECEMBER 21	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 5, 1888	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Lissner				14. MOTHER'S MAIDEN NAME Flora Soloman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mr. MARCUS S Marx - Son - Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL FAILURE 520X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SPONTANEOUS TENSION PNEUMOTHORAX 24 hrs. (c) 24 hrs.						INTERVAL BETWEEN ONSET AND DEATH 1 hr. 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July, 1953, to Dec., 1958, that I last saw the deceased alive on Dec. 21, 1958, and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Hedeman				M.D. 121 Cathedral St.		DATE SIGNED 12/22/58	
PHYSICIAN'S NAME (Type) John Hedeman MD				ADDRESS (Street, city or town, state) Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		22b. DATE THEREOF 12-22-58		22c. NAME OF CEMETERY OR CREMATORY Union Field Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DEC 24 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13294 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13271

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Point Pleasant</u>				d. STREET ADDRESS <u>7</u>	
3. NAME OF DECEASED (Type or print) <u>Roy R. Mostyn</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>1958</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1890</u>		9. AGE (In years last birthday) <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tavern Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bladensburg, Md.</u>	
13. FATHER'S NAME <u>Charles E. Mostyn</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes 1918-19</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-32-9409</u>		17. INFORMANT Address <u>Mrs. Mary C. Mostyn (wife) Point Pleasant</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/23/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 26, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>	
				22d. LOCATION (City, town, or county) (State) <u>Frederick Road Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Krause Funeral Home</u>			24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>		
ADDRESS <u>1216 S. Charles St.</u>			24b. REGISTRAR'S SIGNATURE <u>Gordon S. Krause</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designee, agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1934 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

DEATH RECORD
COUNTY

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO BLOCK

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BED

DATE OF ENTRY INTO CLOSET

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13254

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Rural <u>Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOX Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>Box 321 Rt 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANGELA</u> L Middle <u>NOTHEY</u> Last				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>8</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 27, 1920</u>		9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph A. Drury Sr</u>				14. MOTHER'S MAIDEN NAME <u>Viola Bell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Miss Loretta A. Swan, Daughter Beverly, Mass</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Insider</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accid</u>					
20c. TIME OF INJURY Month, Day, Year <u>8 27 Dec. 8 19 58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt 2</u>		20f. (City or town) (County) (State) <u>Mr Severna Park, Anne Arundel, Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Elmer Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Elmer Linhardt</u>				DATE SIGNED <u>December 8, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-12-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 15 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13295

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13273

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>A. A. County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Churchton Md.</i>		c. LENGTH OF STAY IN 1b <i>Churchton Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Shirley Juanita</i> First Middle Last		4. DATE OF DEATH Month <i>Dec.</i> Day <i>22</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-3-1958</i>
9. AGE (In years last birthday) <i>6</i> yrs.		IF UNDER 12 MONTHS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Earnest Davis</i>		14. MOTHER'S MAIDEN NAME <i>Juanita Offer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Juanita Offer</i> Address <i>Churchton Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute pneumonia</i> 492X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no injury</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Emily H. Wilson, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-24-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Franklin Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Churchton Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Reese #108 Wash. St. Annapolis Md.</i>		24a. REC'D BY REGISTRAR <i>Charles E. Kiser</i>	
24b. REGISTRAR'S SIGNATURE		DATE <i>3 0 '58</i>	

2063181XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13277

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>4 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Minnesota</u> b. COUNTY <u>Ryan</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marshall</u> 60X-3 d. STREET ADDRESS <u>307 Laurel 14th Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Darrell</u> Middle <u>Cletus</u> Last <u>Pelond</u>				4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1958</u>													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 9-1939</u>		9. AGE (In years last birthday) <u>19</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NAVY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u>		11. BIRTHPLACE (State or foreign country) <u>Bloomington, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>									
13. FATHER'S NAME <u>Valmond Earl A.</u>				14. MOTHER'S MAIDEN NAME <u>Husner, Clara Leone</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>7-16-57-6 475-387940</u>		17. INFORMANT <u>U.S. NAVAL Hosp. Annapolis Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fel Embolism</u> <u>902.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture comminuted left femur</u> (c) <u>febrile</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell over 12-foot embankment in the dark.</u>													
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> p. m. <u>12-2</u> 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Moose home yard</u>		20f. (City or town) <u>Annapolis</u> (County) <u>Stco</u> (State) <u>MD</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>12/4/58</u>									
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Marshall</u>		22d. LOCATION (City, town, or county) <u>Marshall</u>		(State) <u>Minn</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Inc. 217 St Paul St Balto -</u>						24a. REC'D BY REGISTRAR DATE <u>DEC 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carl E. Travis</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13274

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital				d. STREET ADDRESS 6 Pinkey Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle PARKER Last PARKER				4. DATE OF DEATH Month December 2 Day 19 Year 58			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-25-1942	
9. AGE (In years last birthday) 16 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Girl		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Lee Parker				14. MOTHER'S MAIDEN NAME Sarah Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Sarah Parker 6 Pinkey St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/3/58			
EXAMINER'S NAME (Type) William V. Lovitt, Jr.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-1958		22c. NAME OF CEMETERY OR CREMATORY St. Marys		22d. LOCATION (City, town, or county) (State) Annapolis Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Kresch, 108 Wash. St. Anna. Md.				24a. REC'D BY REGISTRAR DEC 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13256

CERTIFICATE OF DEATH

13275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Ad. County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Ad. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>		c. LENGTH OF STAY IN 1b <i>10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ad. General Hospital</i>		d. STREET ADDRESS <i>1967 West St.</i>	
3. NAME OF DECEASED (Type or print) <i>Lloyd Leroy Pierce</i>		4. DATE OF DEATH Month <i>12</i> Day <i>22</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-18-1897</i>
9. AGE (In years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Odd Jobs</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mamie Watkins</i>		Address <i>1667 West St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pancrease</i> <i>157x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-17-58</i> to <i>12-22-58</i> , 19____, that I last saw the deceased alive on <i>12-22-58</i> , 19____, and that death occurred at <i>9:10</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. T. Allen</i>		M.D. <i>62 Colchester St</i> ADDRESS (Street, city or town, state) DATE SIGNED <i>12-24-58</i>	
PHYSICIAN'S NAME (Type) <i>A T ALLEN</i>		<i>Annapolis Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-25-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Forsters Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>Bethesda Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Reese</i>		ADDRESS <i>108 Wash. St. Annapolis Md</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <i>EC 30 '58</i>		<i>Allen</i>	

13296 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN 1b <i>3m. 2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Plaza Manor Nursing Home</i>		d. STREET ADDRESS <i>236 Poplar Ave</i>	
3. NAME OF DECEASED (Type or print) <i>James W. Pilkerton</i>		4. DATE OF DEATH <i>December 19 1958</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-1-1867</i>
9. AGE (In years last birthday) <i>91</i>		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Iron Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dietrich Bros</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Unknown</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>MA James M. Pilkerton</i> Address <i>236 Poplar Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis Cardio Vascular Disease</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>—</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <i>—</i> p. m. <i>—</i> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>9-4</i> , 19 <i>58</i> , to <i>last days</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>10-19</i> , 19 <i>58</i> , and that death occurred at <i>12:30 a. m.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James Gruenberg</i>		ADDRESS (Street, city or town, state) <i>P.O. Box 37 Odenton, Md.</i>	
PHYSICIAN'S NAME (Type) <i>James Gruenberg</i>		DATE SIGNED <i>12-19-1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-19-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cmn</i>	22d. LOCATION (City, town, or county) (State) <i>4300 Old Frederick Rd.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Cowan Fun. Home, Balto, Md.</i>		24a. REC'D BY REGISTRAR <i>DEC 22 1958</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

Page 1 of 1

PLACE OF DEATH City or Town		COUNTY	
CITY OR TOWN TO WHICH DEATH OCCURRED		COUNTY	
DATE OF DEATH		TIME OF DEATH	
AGE		SEX	
RACE		RELIGION	
MARRIED		SINGLE	
WIDOWED		DIVORCED	
EDUCATION		OCCUPATION	
BIRTH DATE		BIRTH PLACE	
PARENTS		SPOUSE	
PREVIOUS DEATHS		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL ATTENDANCE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	



13297 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie Md</i>	
c. LENGTH OF STAY IN 1b <i>10 weeks</i>		d. STREET ADDRESS <i>27 Thomas Road - (Country Club Estates)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>27 Thomas Rd. (Country Club Estates)</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William E. Prang</i>		4. DATE OF DEATH <i>12-12-1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>February 25, 1889</i>
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR: Months <i>12</i> Days <i>12</i> Hours <i>12</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cabinet Maker (ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Klumbist Mfg. Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Oshkosh, Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Sophia (Unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>390-10-0836</i>	
17. INFORMANT <i>Mrs. Herta E. Prang</i>		Address <i>Same as #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Vascular Disease</i> 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Artery</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>11</i> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 1 - 59</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Nov 11 - 58</i> , and that death occurred <i>10:50 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph Lipskey</i> M.D.		ADDRESS (Street, city or town, state) <i>Glen Burnie Md</i> DATE SIGNED <i>12-12-58</i>	
PHYSICIAN'S NAME (Type) <i>JOSEPH LIPSKEY</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec 16, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Lake View Mem. Pk.</i>	22d. LOCATION (City, town, or county) (State) <i>Oshkosh, Wisc.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. V. Singleton</i> ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <i>Robert S. Kraus</i>
		DATE <i>DEC 18 '58</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK - ALBANY

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>		<p>RACE</p>	
<p>DATE OF DEATH</p>		<p>TIME OF DEATH</p>		<p>PLACE OF DEATH</p>		<p>CITY</p>	
<p>CAUSE OF DEATH</p>		<p>MANNER OF DEATH</p>		<p>EDUCATION</p>		<p>OCCUPATION</p>	
<p>DATE OF BIRTH</p>		<p>PLACE OF BIRTH</p>		<p>EDUCATION</p>		<p>OCCUPATION</p>	
<p>DATE OF MARRIAGE</p>		<p>PLACE OF MARRIAGE</p>		<p>EDUCATION</p>		<p>OCCUPATION</p>	
<p>DATE OF DEATH</p>		<p>TIME OF DEATH</p>		<p>PLACE OF DEATH</p>		<p>CITY</p>	
<p>CAUSE OF DEATH</p>		<p>MANNER OF DEATH</p>		<p>EDUCATION</p>		<p>OCCUPATION</p>	
<p>DATE OF BIRTH</p>		<p>PLACE OF BIRTH</p>		<p>EDUCATION</p>		<p>OCCUPATION</p>	
<p>DATE OF MARRIAGE</p>		<p>PLACE OF MARRIAGE</p>		<p>EDUCATION</p>		<p>OCCUPATION</p>	

ALBANY

NEW YORK

STATE OF NEW YORK



STATE OF NEW YORK - ALBANY

13298

CERTIFICATE OF DEATH

13280

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Anne Arundel Co</i> b. COUNTY <i>Anne Arundel Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mary Catherine Queen</i> First Middle Last		4. DATE OF DEATH <i>12-24</i> 19 <i>58</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 25, 1889</i> <i>69</i> yrs.
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S</i>	
13. FATHER'S NAME <i>Edwin Gamblie</i>		14. MOTHER'S MAIDEN NAME <i>Priscilla Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Wm E. Queen</i> Address <i>Severna Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO (b) <i>Malignant Hypertension</i> DUE TO (c) <i>Sudden</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost? <i>Cardio Vascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 23, 1958</i> to <i>Dec 24, 1958</i> that I last saw the deceased alive on <i>Dec 23, 1958</i> , and that death occurred at <i>11 A</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Severna Md</i> DATE SIGNED <i>12-24-58</i>	
ACTUAL SIGNATURE <i>Joseph Lipskey</i> M.D.			
PHYSICIAN'S NAME (Type) <i>DR. JOSEPH LIPSKEY</i>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Burial</i> DATE THEREOF <i>Dec 29, 1958</i>		22b. NAME OF CEMETERY OR CREMATORY <i>Balto. National Cem. Balto Md.</i>	
22c. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs. Katie R. Williams</i> ADDRESS <i>322 N Schroeder St</i>		24a. REC'D BY REGISTRAR <i>DEC 29 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1938

DATE OF DEATH

DECEASED

PLACE HERE

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

PLACE HERE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13299

CERTIFICATE OF DEATH

Reg. Dist. No.

13281

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD 2 - Box 221</u>				d. STREET ADDRESS <u>RFD 2 - Box 221</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Mary (Mamie) I. Roach</u>		4. DATE OF DEATH Month Day Year <u>December 27 1958</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1883</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Edward J. McCann</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Welsh</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-10-3550</u>		17. INFORMANT <u>Frank T. Roach Pasadena, A.A. Co. Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>Cardiac decompensation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>5 years</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 2, 1955</u> , to <u>December 27, 1958</u> , that I last saw the deceased alive on <u>December 26, 1958</u> , and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u> DATE SIGNED <u>Dec. 27, 1958</u>							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>		M.D. <u>Pasadena, Md. Dec. 27, 1958</u>					
PHYSICIAN'S NAME (Type) <u>Randall M. McLaughlin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 30, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's (Govans)</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home</u> <u>Horace F. Burgee</u>				ADDRESS <u>3631 Falls Road</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>			

CERTIFICATE OF DEATH

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13300 CERTIFICATE OF DEATH

13282

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 4m 9d			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1104 Riggs Avenue - 2nd Floor			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Rose Middle Mary Last Robinson				4. DATE OF DEATH Month 12 Day 4 Year 19 58			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1878	
9. AGE (In years last birthday) yrs. 80?		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Robinson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition - Generalized & Cerebral 334x DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO Senility (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from 7/25 , 19 58 , to 12/4 , 19 58 , that I last saw the deceased alive on 12/4 , 19 58 , and that death occurred at 8:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE [Signature] M.D. Crownsville State Hospital 12/8/58 PHYSICIAN'S NAME (Type) L. Benedict, M. D. Crownsville State Hospital 12/8/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal 12-10-58				22b. DATE THEREOF 12-10-58		22c. NAME OF CEMETERY OR CREMATORY W.M.V. of Md	
22d. LOCATION (City, town, or county) (State) Baltimore, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				24a. REC'D BY REGISTRAR DEC 12 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13258

CERTIFICATE OF DEATH

13283

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY aa MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE md b. COUNTY aa	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) A. G. General	d. STREET ADDRESS 1206 Wardour Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Neida Middle Parks Last Ross		4. DATE OF DEATH Month 12 Day 16 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-1890
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Governess		10b. KIND OF BUSINESS OR INDUSTRY Private Home	
11. BIRTH PLACE (State or foreign country) Big Island Va		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Will Toode Parks		14. MOTHER'S MAIDEN NAME Susan Eliza Surpin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Herbert J. Saunders		Address 211 4th Ave Quantico Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY THROMBOSIS DUE TO (c) HYPERTENSIVE HEART DISEASE			INTERVAL BETWEEN ONSET AND DEATH 1 Hour 1 Hour 8 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JUL 6 , 1957, to 16 DEC , 1958, that I last saw the deceased alive on 12/16 , 1958, and that death occurred at 8:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward S. Beck M.D.		ADDRESS (Street, city or town, state) 41 Southgate Ave DATE SIGNED 12/17/58	
PHYSICIAN'S NAME (Type) EDWARD S. BECK		Annapolis Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-19-58	22c. NAME OF CEMETERY OR CREMATORY Bedford Cent	22d. LOCATION (City, town, or county) (State) Bedford Va
23. FUNERAL DIRECTOR'S SIGNATURE John M. Sayle Sons		24a. REC'D BY REGISTRAR Annapolis Md DATE DEC 19 1958	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

Item 18 Film 236 12-24-58 ams

13259 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annapolis Genl Hospital</u>				d. STREET ADDRESS <u>111 New Jersey Ave. N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mrs. Jessie M. Rummel</u>		First Middle Last		4. DATE OF DEATH		Month Day Year <u>December 12 19 58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 30, 1903</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Leonardtown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u> <u>Newton</u>		14. MOTHER'S MAIDEN NAME <u>?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. John J. Rummel,</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Carcinomatosis</u> DUE TO (c) <u>Primary site left breast</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>4 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 16, 1958</u> , to <u>Dec 12, 1958</u> , that I last saw the deceased alive on <u>Dec 11, 1958</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u>				ADDRESS (Street, city or town, state) <u>Mountain Rd. Rt. #8 Pasadena Maryland</u>			
DATE SIGNED <u>DEC 12 '58</u>							
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>DEC 17 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Ruck</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 11, See: Birth Cert. et

CERTIFICATE OF DEATH

14422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b Severn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Anne Arundel General Hospital				d. STREET ADDRESS ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Patrick Last Ryan				4. DATE OF DEATH Month December Day 18 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 17, 1958	
9. AGE (In years last birthday) 14 yrs.		IF UNDER 1 YEAR Months 14 Days 58		IF UNDER 24 HRS. Hours 14 Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Sonja Mae Ryan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address Box 132, Severn, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776 X Immaturity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 14 hrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 17 Dec 19 58 to 18 Dec 19 58 , that I last saw the deceased alive on 17 Dec 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 141 CROSBY ST DATE SIGNED 23 Dec 58 ACTUAL SIGNATURE Stuart H. Walker MD M.D. PHYSICIAN'S NAME (Type) STUART H. WALKER MD							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1-6-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING				24a. REC'D BY REGISTRAR JAN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

2063181XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G237 1-7-59 et

13301

CERTIFICATE OF DEATH

13285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE STATE HOSP.		d. STREET ADDRESS 1607 Mc Kean Ave.	
3. NAME OF DECEASED (Type or print) First CHARIE Middle SCAYLES Last		4. DATE OF DEATH Month 12 Day 27 Year 1958	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12. Oct. 1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto city		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS - Crownsville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary collapse 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia Hypostatic pneumonia (c) Pyelitis Gangren of left leg. 7 weeks. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/6/58 1958, to 12/27/58 1958, that I last saw the deceased alive on 12/27/58 , 1958, and that death occurred at 9 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownville State Hospital DATE SIGNED			
ACTUAL SIGNATURE L. Benedict M.D. M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) L. BENEDICT M.D.		Crownville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 12/31/58	22c. NAME OF CEMETERY OR CREMATORY St. Albans	22d. LOCATION (City, town, or county) (State) Calver
23. FUNERAL DIRECTOR'S SIGNATURE Hollan & Funnell Home ADDRESS 1631		24a. REC'D BY REGISTRAR DATE DEC 30 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13286

13261 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GUY L. SEAMAN</u>				4. DATE OF DEATH <u>DEC. 26 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-6-74</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Interstate Commerce</u>		11. BIRTHPLACE (State or foreign country) <u>Newtown, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Not Available</u>				14. MOTHER'S MAIDEN NAME <u>Not Available</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Eldene Wilson, 10 Fairglen Rd, Annapolis Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>9 DEC 1958</u> , to <u>26 DEC 1958</u> , that I last saw the deceased alive on <u>26 DEC 1958</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>41 Southgate Ave</u>			
DATE SIGNED <u>12/26/58</u>							
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK M.D. ANNAPOLIS, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec 29, 1958</u>		<u>Fair Lincoln Cemetery</u>		<u>Prince Geo. County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters, 254 Carroll Ave NW S.C.</u>				24a. REC'D BY REGISTRAR <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13302 CERTIFICATE OF DEATH

Reg. Dist. No. 27

13287

1. PLACE OF DEATH o. COUNTY Anne Arundel c. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		/ d. STREET ADDRESS Co C 69th Sig Bn	
3. NAME OF DECEASED (Type or print) First ROBERT Middle Clinton Last SHIPP		4. DATE OF DEATH Month December Day 7 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 August 1921
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Paul Shipp	
14. MOTHER'S MAIDEN NAME Marjorie Louise Westmore		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II	
16. SOCIAL SECURITY NO. 224-24-5830		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic necrosis of Pancreas 587.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 0800 7 Dec., 1958 , to 1845 7 Dec., 1958 , that I last saw the deceased alive on 1800 7 Dec., 1958 , and that death occurred at 645 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stanley Seigelman M.D. U. S. Army Hospital, Ft Meade, Md 7 Dec 58 PHYSICIAN'S NAME (Type) STANLEY SEIGELMAN, Capt, MC U.S. Army Hospital, Ft Meade, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-10-58	
22c. NAME OF CEMETERY OR CREMATORY Alleghany Mem. Burial Park		22d. LOCATION (City, town, or county) (State) Lowmorr, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook Inc. 1217 St. Paul Baltimore, Md.		24a. REC'D BY REGISTRAR DEC 11 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

13262 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in the county, give street address) OR INSTITUTION <i>215 W. Linden Ave</i>		d. STREET ADDRESS <i>1215 W. Linden Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Edith Mae Sinclair</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr-24-1900</i>
9. AGE (In years last birthday) <i>58</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13. BIRTHPLACE (State or foreign country) <i>Bosman Md</i>		14. CITIZEN OF WHAT COUNTRY? <i>U. S A</i>	
15. FATHER'S NAME <i>John Francis Kerper</i>		16. MOTHER'S MAIDEN NAME <i>Juvenia McQuay</i>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO. <i>-</i>	
19. INFORMANT <i>Alfred W. Sinclair</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>592X</i> DUE TO <i>chronic nephritis with nephrosis -</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i> DUE TO (c) <i>myocardial failure</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May</i> , 1957, to <i>Dec 30</i> , 1958, that I last saw the deceased alive on <i>Dec 27</i> , 1958, and that death occurred at <i>8:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Emily H. Nelson</i> M.D.		ADDRESS (Street, city or town, state) <i>Lothian, Md.</i> DATE SIGNED <i>12-31-58</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-2-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven</i>		22d. LOCATION (City, town, or county) (State) <i>Glen Burnie Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i> ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR <i>JAN 5 '59</i> DATE	
24b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13263 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS c. LENGTH OF STAY IN 1b ANNAPOLIS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOA ANNE ARUNDEL GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X WHITE HALL BEACH RFD 2 d. STREET ADDRESS ANNAPOLIS, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES R SPOERL			4. DATE OF DEATH Month Day Year DECEMBER 29 1958				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 1, 1890		9. AGE (In years last birthday) 68 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Pinter		10b. KIND OF BUSINESS OR INDUSTRY Printing shop		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Spoerl			14. MOTHER'S MAIDEN NAME Minnie R. Fox.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 094 10 4578		17. INFORMANT Mrs Louise H. Spoerl- Wife -Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension CVD DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 13 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from 8-14- 19 57 to 12-9- 19 57 , that I last saw the deceased alive on 12-9- 19 57 , and that death occurred at 12 noon from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank Shipley		M.D. 1215 Catheches St - 12-30-58		ADDRESS (Street, city or town, state) Annopolis, Maryland			
PHYSICIAN'S NAME (Type) Frank Shipley MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 2, 1959	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR JAN 2 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Knard		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13303

CERTIFICATE OF DEATH

13290

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>GA Co</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> c. LENGTH OF STAY IN 1b <u>2 yr</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>GA Co</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pasadena Rt 7 Box 466</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pasadena (Lake Shore)</u>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Crawford</u> Last <u>Thellman</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 25-1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Sam Thellman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Thellman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Kathleen Potter 800 Seagrave Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia, terminal</u> <u>593x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Vascular nephritis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 year</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493x</u> <u>Cachexia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>58</u> , to <u>Dec 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>58</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mountain Rd Rt #8</u> DATE SIGNED ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u> M.D. <u>Pasadena, Maryland</u> PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, & county) (State)	
<u>Interment</u>		<u>Dec 18-58</u>		<u>Union Chapel Cemetery</u>		<u>Plymouth NC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard G. Smith</u>				24. REC'D BY REGISTRAR DATE <u>DEC 17 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kross</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DEPT. OF

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of death: <i>10/15/1918</i></p>	
<p>5. Place of death: <i>Home</i></p>		<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Immediate cause: <i>Myocardial Infarction</i></p>		<p>8. Underlying cause: <i>Coronary Artery Disease</i></p>	
<p>9. Contributing cause: <i>None</i></p>		<p>10. Manner of death: <i>Natural</i></p>	
<p>11. Signature of physician: <i>[Signature]</i></p>		<p>12. Signature of registrar: <i>[Signature]</i></p>	
<p>13. Date of registration: <i>10/16/1918</i></p>		<p>14. Office of registration: <i>City of New York</i></p>	

RECEIVED
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 OCT 16 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13291

13304 • CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 3y 10m 11d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1248 N. Bay Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mamie Middle Ann Last Stokes		4. DATE OF DEATH Month 12 Day 15 Year 19 58			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 15, 1888	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months 12 Days 15 Hours 58 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fletcher Jones		14. MOTHER'S MAIDEN NAME Pricilla Perry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 433.1 DUE TO Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Aricular Fiabbrillation (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis, Epilepsy, Senility & Decubitus Ulcers					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----		20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from 2/4 , 19 55 , to 12/15 , 19 58 , that I last saw the deceased alive on 12/15 , 19 58 , and that death occurred at 4:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 12/15/58 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md. 12/15/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/58		22c. NAME OF CEMETERY OR CREMATORY Jones Chapel Cem. Rockville N.C.	
22d. LOCATION (City, town, or county) Rockville N.C.		22e. (State) N.C.		22f. (Country) U.S.A.	
23. FUNERAL DIRECTOR'S SIGNATURE Randolph Collich		23a. ADDRESS 1412 E. Preston St.		23b. REC'D BY REGISTRAR DEC 23 '58	
23c. REGISTRAR'S SIGNATURE Arthur S. Kears		23d. DATE DEC 23 '58		23e. REGISTRAR'S SIGNATURE Arthur S. Kears	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
1904 • CERTIFICATE OF DEATH

Name of deceased		Age		Sex		Race		Color	
John Doe		45		Male		White		White	
Place of birth		Date of birth		Cause of death		Duration of illness		Place of death	
New York		Jan 1, 1859		Heart disease		10 days		Home	
Occupation		Married		Signature of physician		Signature of registrar		Date	
Teacher		Yes		J. B. Smith		A. C. Jones		Jan 15, 1904	
Signature of informant		Name of informant		Address of informant		City		State	
W. B. Brown		John Doe		123 Main St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
J. C. White		J. C. White		456 Oak St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
D. E. Green		D. E. Green		789 Pine St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
F. G. Black		F. G. Black		101 Elm St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
H. I. Blue		H. I. Blue		202 Maple St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
K. L. Red		K. L. Red		303 Cedar St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
M. N. Yellow		M. N. Yellow		404 Birch St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
O. P. Purple		O. P. Purple		505 Walnut St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
Q. R. Grey		Q. R. Grey		606 Chestnut St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
S. T. Brown		S. T. Brown		707 Spruce St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
U. V. Green		U. V. Green		808 Ash St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
W. X. Blue		W. X. Blue		909 Hickory St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
Y. Z. Red		Y. Z. Red		1010 Sycamore St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
A. B. Yellow		A. B. Yellow		1111 Poplar St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
C. D. Purple		C. D. Purple		1212 Magnolia St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
E. F. Grey		E. F. Grey		1313 Dogwood St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
G. H. Brown		G. H. Brown		1414 Redwood St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
I. J. Green		I. J. Green		1515 Cypress St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
K. L. Blue		K. L. Blue		1616 Juniper St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
M. N. Red		M. N. Red		1717 Fir St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
O. P. Yellow		O. P. Yellow		1818 Palm St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
Q. R. Purple		Q. R. Purple		1919 Olive St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
S. T. Grey		S. T. Grey		2020 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
U. V. Brown		U. V. Brown		2121 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
W. X. Blue		W. X. Blue		2222 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
Y. Z. Red		Y. Z. Red		2323 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
A. B. Yellow		A. B. Yellow		2424 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
C. D. Purple		C. D. Purple		2525 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
E. F. Grey		E. F. Grey		2626 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
G. H. Brown		G. H. Brown		2727 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
I. J. Green		I. J. Green		2828 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
K. L. Blue		K. L. Blue		2929 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
M. N. Red		M. N. Red		3030 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
O. P. Yellow		O. P. Yellow		3131 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
Q. R. Purple		Q. R. Purple		3232 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
S. T. Grey		S. T. Grey		3333 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
U. V. Brown		U. V. Brown		3434 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
W. X. Blue		W. X. Blue		3535 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
Y. Z. Red		Y. Z. Red		3636 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
A. B. Yellow		A. B. Yellow		3737 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
C. D. Purple		C. D. Purple		3838 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
E. F. Grey		E. F. Grey		3939 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
G. H. Brown		G. H. Brown		4040 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
I. J. Green		I. J. Green		4141 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
K. L. Blue		K. L. Blue		4242 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
M. N. Red		M. N. Red		4343 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
O. P. Yellow		O. P. Yellow		4444 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
Q. R. Purple		Q. R. Purple		4545 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
S. T. Grey		S. T. Grey		4646 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
U. V. Brown		U. V. Brown		4747 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
W. X. Blue		W. X. Blue		4848 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
Y. Z. Red		Y. Z. Red		4949 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
A. B. Yellow		A. B. Yellow		5050 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
C. D. Purple		C. D. Purple		5151 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
E. F. Grey		E. F. Grey		5252 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
G. H. Brown		G. H. Brown		5353 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
I. J. Green		I. J. Green		5454 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
K. L. Blue		K. L. Blue		5555 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
M. N. Red		M. N. Red		5656 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
O. P. Yellow		O. P. Yellow		5757 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
Q. R. Purple		Q. R. Purple		5858 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
S. T. Grey		S. T. Grey		5959 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
U. V. Brown		U. V. Brown		6060 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
W. X. Blue		W. X. Blue		6161 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
Y. Z. Red		Y. Z. Red		6262 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
A. B. Yellow		A. B. Yellow		6363 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
C. D. Purple		C. D. Purple		6464 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
E. F. Grey		E. F. Grey		6565 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
G. H. Brown		G. H. Brown		6666 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
I. J. Green		I. J. Green		6767 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
K. L. Blue		K. L. Blue		6868 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
M. N. Red		M. N. Red		6969 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
O. P. Yellow		O. P. Yellow		7070 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
Q. R. Purple		Q. R. Purple		7171 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
S. T. Grey		S. T. Grey		7272 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
U. V. Brown		U. V. Brown		7373 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
W. X. Blue		W. X. Blue		7474 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
Y. Z. Red		Y. Z. Red		7575 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
A. B. Yellow		A. B. Yellow		7676 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
C. D. Purple		C. D. Purple		7777 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
E. F. Grey		E. F. Grey		7878 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
G. H. Brown		G. H. Brown		7979 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
I. J. Green		I. J. Green		8080 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
K. L. Blue		K. L. Blue		8181 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
M. N. Red		M. N. Red		8282 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
O. P. Yellow		O. P. Yellow		8383 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
Q. R. Purple		Q. R. Purple		8484 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
S. T. Grey		S. T. Grey		8585 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
U. V. Brown		U. V. Brown		8686 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
W. X. Blue		W. X. Blue		8787 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
Y. Z. Red		Y. Z. Red		8888 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
A. B. Yellow		A. B. Yellow		8989 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
C. D. Purple		C. D. Purple		9090 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
E. F. Grey		E. F. Grey		9191 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
G. H. Brown		G. H. Brown		9292 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City		State	
I. J. Green		I. J. Green		9393 Plum St		Baltimore		Md	
Signature of undertaker		Name of undertaker		Address of undertaker		City		State	
K. L. Blue		K. L. Blue		9494 Apple St		Baltimore		Md	
Signature of coroner		Name of coroner		Address of coroner		City		State	
M. N. Red		M. N. Red		9595 Pear St		Baltimore		Md	
Signature of registrar		Name of registrar		Address of registrar		City		State	
O. P. Yellow		O. P. Yellow		9696 Peach St		Baltimore		Md	
Signature of physician		Name of physician		Address of physician		City		State	
Q. R. Purple		Q. R. Purple		9797 Cherry St		Baltimore		Md	
Signature of informant		Name of informant		Address of informant		City			

13305

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 9y 5m 3d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 528 Johannsen Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Franklin		4. DATE OF DEATH Month 12 Day 10 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 22, 1893
9. AGE (In years lost birthday) yrs. 65		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Markaly La Taylor		14. MOTHER'S MAIDEN NAME Mary Franklin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition and Dehydration 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Carcinoma of Esophagus DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcoholic Psychosis, Delirium Tremens			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 7/7 , 19 49 , to 12/10 , 19 58 , that I last saw the deceased alive on 12/10 , 19 58 , and that death occurred at 3:35A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 12/10/58 ACTUAL SIGNATURE [Signature] M.D. Crownsville State Hospital, Md. 12/10/58 PHYSICIAN'S NAME (Type) L. Benedict, M. D. Crownsville State Hospital, Md. 12/10/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried Dec 11 - 58	22b. DATE THEREOF Dec 11 - 58	22c. NAME OF CEMETERY OR CREMATORY OT Md	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE William R. Rouse		24a. REC'D BY REGISTRAR DATE DEC 12 1958	
ADDRESS 108 Washington St		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Thompson

Item 7 Film 6237 1-2-59 et

13306

CERTIFICATE OF DEATH

Reg. Dist. No.

13293

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>U. S. Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville St Hospt</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Idella Thomas</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

13. FATHER'S NAME <u>BENJAMIN ALLEN</u>		14. MOTHER'S MAIDEN NAME <u>IDA SNOWDEN</u>	
---	--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>HATTIE THOMAS-SIMPSONVILLE MD</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 522x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypostatic Pneumonia</u> DUE TO (c) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u>
--	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome = Cerebral Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 26, 1958 to Dec 26, 1958 that I last saw the deceased alive on Dec 26, 1958, and that death occurred at 4 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE <u>Wilbur A. Hamman</u> M.D.	ADDRESS (Street, city or town, state) <u>12/26/58</u>	DATE SIGNED
PHYSICIAN'S NAME (Type) <u>Wilbur A. Hamman</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-30-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOCUST CHAPEL</u>	22d. LOCATION (City, town, or county) (State) <u>SIMPSONVILLE MD</u>
---	-----------------------------------	---	--

23. FUNERAL DIRECTOR'S SIGNATURE <u>F. E. Higginbotham</u>	ADDRESS <u>Fellicott City, Md.</u>	24a. REC'D BY REGISTRAR <u>DEC 29 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton S. Knecht</u>
--	------------------------------------	---	---

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13264 CERTIFICATE OF DEATH

13294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>183 CLAY STREET</u>				d. STREET ADDRESS <u>183 CLAY ST.</u>			
3. NAME OF DECEASED (Type or print) <u>ESTELLA TOODLES</u> First Middle Last <u>TOODLES</u>				4. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-90</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>A.A., Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Frederick Toodles</u>				14. MOTHER'S MAIDEN NAME <u>MARY TIDUS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Edward Pindell-183 CLAY ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>159x</u> IMMEDIATE CAUSE (a) <u>Carcinoma of Sigmoid Tract</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 15 1958</u> to <u>12-21-58</u> , that I last saw the deceased alive on <u>12-20-58</u> , 19 <u>58</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. T. Allen</u>				ADDRESS (Street, city or town, state) <u>M.D. 6 E. Calvary St</u>			
DATE SIGNED <u>12-21-58</u>				DATE SIGNED <u>12-21-58</u>			
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>				PHYSICIAN'S NAME (Type) <u>ANNAPOLIS MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT CALVARY</u>		22d. LOCATION (City, town, or county) (State) <u>ARNOLD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES E. HICKS II</u> ADDRESS <u>ANNA, MD</u>				24a. REC'D BY REGISTRAR <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Pindell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13307 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Crownsville</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>2/13/58</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 03X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>919 Naca Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>B.</u> Last <u>WALLACE</u>				4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/4/1933</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Va - USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Bill Wallace (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Mr. Martha Davis Wallace (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hospital records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypertatic pneumonia bilateral</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocardial disease with old infarction</u> DUE TO (c) <u>chronic brain syndrome associated arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12/9/58</u> <u>12/9/58</u> <u>2/13/58</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 13</u> , 19 <u>58</u> , to <u>Dec. 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 24</u> , 19 <u>58</u> , and that death occurred at <u>5 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Benedict M.D.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Crownsville State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>				<u>Crownsville Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-31-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crownsville Mt.</u>		22d. LOCATION (City, town, or county) (State) <u>Crownsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas E. Nelson</u>				ADDRESS <u>1303 Westman St</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12301 - CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

DATE OF DEATH

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RECEIVED
MAY 10 1961
BALTIMORE
DEPT. OF HEALTH

RECEIVED
MAY 10 1961
BALTIMORE
DEPT. OF HEALTH

RECEIVED
MAY 10 1961
BALTIMORE
DEPT. OF HEALTH

RECEIVED
MAY 10 1961
BALTIMORE
DEPT. OF HEALTH

RECEIVED
MAY 10 1961
BALTIMORE
DEPT. OF HEALTH

13308

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Same b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S. Crain Highway				d. STREET ADDRESS Same			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Clarence L. Warfield				4. DATE OF DEATH Month Day Year December 15th. 19 58			
5. SEX M.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/84	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkridge, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Warfield				14. MOTHER'S MAIDEN NAME ? Cole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-9334		17. INFORMANT Address Mrs. Myrtle Warfield (wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden 10 y.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/15/58 , 19 47 , to 12/15/58 , 19 58 , that I last saw the deceased alive on 12/15/58 , 19 58 , and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glen Burnie, Md. DATE SIGNED 12/15/58							
ACTUAL SIGNATURE Gustave H. Faubert, M.D.				M.D. Glen Burnie, Md.			
PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/18/58		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Minkley ADDRESS Glen Burnie				24a. REC'D BY REGISTRAR DATE DEC 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13265 CERTIFICATE OF DEATH

13297

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				d. STREET ADDRESS <u>11958 Forrest Dr.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM Henry WATKINS</u>				4. DATE OF DEATH Month Day Year <u>12 5 1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>COL</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 20-1884</u>	
9. AGE (In years last birthday) yrs. <u>74</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>74</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HAULING - GENERAL</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ANNAPOLIS CO</u>			
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS CO</u>				12. CITIZEN OF WHAT COUNTRY? <u>—</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Louise Henson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>ANNIE E. MURDEN-1958 Forrest Drive</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>493X</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/4</u> , 19 <u>58</u> , to <u>12/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/4</u> , 19 <u>58</u> , and that death occurred at <u>2:40</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Hedeman</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John Hedeman</u>				DATE SIGNED <u>12/5/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES E. HICKS III</u>				ADDRESS <u>ANNAPOLIS - Md.</u>			
24a. REC'D BY REGISTRAR <u>DEC 11 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hicks</u>			

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE SIGNED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE SIGNED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

1899

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. TIME OF DEATH</p>		<p>10. PLACE OF DEATH</p>		<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF PHYSICIAN</p>		<p>16. SIGNATURE OF REGISTRAR</p>		<p>17. SIGNATURE OF WITNESSES</p>		<p>18. SIGNATURE OF DECEASED</p>	
<p>19. SIGNATURE OF PHYSICIAN</p>		<p>20. SIGNATURE OF REGISTRAR</p>		<p>21. SIGNATURE OF WITNESSES</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF PHYSICIAN</p>		<p>24. SIGNATURE OF REGISTRAR</p>	
<p>25. SIGNATURE OF WITNESSES</p>		<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF PHYSICIAN</p>		<p>28. SIGNATURE OF REGISTRAR</p>		<p>29. SIGNATURE OF WITNESSES</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF PHYSICIAN</p>		<p>32. SIGNATURE OF REGISTRAR</p>		<p>33. SIGNATURE OF WITNESSES</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF PHYSICIAN</p>		<p>36. SIGNATURE OF REGISTRAR</p>	
<p>37. SIGNATURE OF WITNESSES</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF PHYSICIAN</p>		<p>40. SIGNATURE OF REGISTRAR</p>		<p>41. SIGNATURE OF WITNESSES</p>		<p>42. SIGNATURE OF DECEASED</p>	
<p>43. SIGNATURE OF PHYSICIAN</p>		<p>44. SIGNATURE OF REGISTRAR</p>		<p>45. SIGNATURE OF WITNESSES</p>		<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF PHYSICIAN</p>		<p>48. SIGNATURE OF REGISTRAR</p>	
<p>49. SIGNATURE OF WITNESSES</p>		<p>50. SIGNATURE OF DECEASED</p>		<p>51. SIGNATURE OF PHYSICIAN</p>		<p>52. SIGNATURE OF REGISTRAR</p>		<p>53. SIGNATURE OF WITNESSES</p>		<p>54. SIGNATURE OF DECEASED</p>	
<p>55. SIGNATURE OF PHYSICIAN</p>		<p>56. SIGNATURE OF REGISTRAR</p>		<p>57. SIGNATURE OF WITNESSES</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF PHYSICIAN</p>		<p>60. SIGNATURE OF REGISTRAR</p>	
<p>61. SIGNATURE OF WITNESSES</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF PHYSICIAN</p>		<p>64. SIGNATURE OF REGISTRAR</p>		<p>65. SIGNATURE OF WITNESSES</p>		<p>66. SIGNATURE OF DECEASED</p>	
<p>67. SIGNATURE OF PHYSICIAN</p>		<p>68. SIGNATURE OF REGISTRAR</p>		<p>69. SIGNATURE OF WITNESSES</p>		<p>70. SIGNATURE OF DECEASED</p>		<p>71. SIGNATURE OF PHYSICIAN</p>		<p>72. SIGNATURE OF REGISTRAR</p>	
<p>73. SIGNATURE OF WITNESSES</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF PHYSICIAN</p>		<p>76. SIGNATURE OF REGISTRAR</p>		<p>77. SIGNATURE OF WITNESSES</p>		<p>78. SIGNATURE OF DECEASED</p>	
<p>79. SIGNATURE OF PHYSICIAN</p>		<p>80. SIGNATURE OF REGISTRAR</p>		<p>81. SIGNATURE OF WITNESSES</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF PHYSICIAN</p>		<p>84. SIGNATURE OF REGISTRAR</p>	
<p>85. SIGNATURE OF WITNESSES</p>		<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF PHYSICIAN</p>		<p>88. SIGNATURE OF REGISTRAR</p>		<p>89. SIGNATURE OF WITNESSES</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF PHYSICIAN</p>		<p>92. SIGNATURE OF REGISTRAR</p>		<p>93. SIGNATURE OF WITNESSES</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF PHYSICIAN</p>		<p>96. SIGNATURE OF REGISTRAR</p>	
<p>97. SIGNATURE OF WITNESSES</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF PHYSICIAN</p>		<p>100. SIGNATURE OF REGISTRAR</p>		<p>101. SIGNATURE OF WITNESSES</p>		<p>102. SIGNATURE OF DECEASED</p>	

13266

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH FRANKLIN WHITTINGTON</u>		4. DATE OF DEATH Month Day Year <u>DECEMBER 23 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 22, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Franklin Whittington</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Litch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>217-16-8504</u>	
17. INFORMANT <u>Mrs Agnes Owens Whittington- Wife- same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>XX</u> <u>12-23-58</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Annapolis A.A. Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-26-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tracy's Anne Arundel Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13267

CERTIFICATE OF DEATH

Reg. Dist. No.

13301

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>133 West Street</u>		d. STREET ADDRESS <u>133 West Street</u>	
3. NAME OF DECEASED (Type or print) <u>Aunice Viola Whipple</u> First Middle Last		4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Will Green</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Sharps</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Richard Whipple 133 West St.</u>	
17. INFORMANT Address <u>Richard Whipple 133 West St.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardium infarction</u> <u>744.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>groves</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-17-58</u> , 19 <u>58</u> , to <u>12-27-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-27-58</u> , 19 <u>58</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>AT Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 Cochrane St</u> DATE SIGNED <u>12-28-58</u>	
PHYSICIAN'S NAME (Type) <u>AT ALLEN</u>		<u>annapolis md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-31-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hall</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Reese #108 Wash St. Annapolis</u>		24a. REC'D BY REGISTRAR <u>DEC 30 58</u>	
24b. REGISTRAR'S SIGNATURE			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13310 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 3 years 10 months 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 2014 E. Hoffman Street	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN WILKERSON		4. DATE OF DEATH Month Day Year December 2, 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 35 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) North Carolina; Oxford
13. FATHER'S NAME Jack Wilkerson		14. MOTHER'S MAIDEN NAME Esther Shanks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Eliza Wilkerson	
17. INFORMANT Eliza Wilkerson		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia due to Craniocerebral Injury and Fracture of Leg DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian hit by auto	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8:25 a.m. 10/2/58 19	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	20f. (City or town) (County) (State) Baltimore Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DATE SIGNED 12/4/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 8, 1958	22c. NAME OF CEMETERY OR CREMATORY Johnson Creek Cemetery	22d. LOCATION (City, town, or county) (State) Oxford; North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE ELROY O. WILSON		24a. REC'D BY REGISTRAR DATE DEC 22 '58	
ADDRESS 1000 Brantley Avenue		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1330

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

First Name		Last Name	
John		D. Wilson	
Sex		Male	
Age		45	
Race		White	
Birth Date		1900	
Birth Place		Maryland	
Marital Status		Married	
Spouse Name		Mary D. Wilson	
Occupation		Teacher	
Cause of Death		Heart Disease	
Date of Death		Jan 1, 1955	
Place of Death		Home	
Physician		Dr. J. H. Smith	
Hospital		None	
Burial Place		St. Mary's Cemetery	
Burial Date		Jan 5, 1955	
Signature		[Signature]	
Print Name		John D. Wilson	
Address		1000 Broadway Avenue	
City		Baltimore	
State		Maryland	
Zip		21201	

13303

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13302

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b X Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Schmuck Dump		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSH WITHERSPOON		4. DATE OF DEATH December 7 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Greenberg, North Carolina	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Daisy E. Smith (Common Law Wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.0 Exposure secondary to Acute Alcoholism. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 322.0 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Exposure to cold.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Exposure to cold.	
20c. TIME OF INJURY Month, Day, Year Hour 12:00 12/7/58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Schmuck Dump	20f. (City or town) (County) (State) Glen Burnie A.A. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/8/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 12, 1958	22c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cemetery	22d. LOCATION (City, town, or county) (State) Brooklyn, Anne Arundel Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE ELROY O. WILSON		24a. REC'D BY REGISTRAR DEC 22 '58	
ADDRESS FUNERAL HOME 1000 Brantley Ave.		24b. REGISTRAR'S SIGNATURE Arthur S. Hana	

Antennae 11-segmented, 1st segment 1.5 times length of 2nd segment, 3rd segment 1.5 times length of 2nd segment, 4th segment 1.5 times length of 2nd segment, 5th segment 1.5 times length of 2nd segment, 6th segment 1.5 times length of 2nd segment, 7th segment 1.5 times length of 2nd segment, 8th segment 1.5 times length of 2nd segment, 9th segment 1.5 times length of 2nd segment, 10th segment 1.5 times length of 2nd segment, 11th segment 1.5 times length of 2nd segment.

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13268 CERTIFICATE OF DEATH

Reg. Dist. No. 13303

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>RT 1 Box 217</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Ruth</u> Last <u>Whitt</u>		4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 2, 1958</u>
9. AGE (In years lost birthday) yrs. <u>12</u>		IF UNDER 1 YEAR Months <u>12</u> Days <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ned Whitt</u>		14. MOTHER'S MAIDEN NAME <u>Iris Nicewander</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mother</u>		Address <u>Rt. 1, Box 217, Arnold, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>770.0 Hemolytic Disease of Newborn</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 3</u> , 19 <u>58</u> , to <u>Dec 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 3</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>12-5-58</u>			
ACTUAL SIGNATURE <u>Ned H. Sims</u> M.D.			
PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-6-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Layman & Sons</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '58</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2063364XV5

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1925</i>	
9. NAME OF SPOUSE <i>Mary E. Smith</i>		10. DATE OF DEATH <i>Dec 10 1945</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>	
15. SIGNATURE OF WITNESS <i>John A. Smith</i>		16. SIGNATURE OF DECEASED <i>John A. Smith</i>	
17. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		18. SIGNATURE OF MINISTER <i>Rev. W. B. Brown</i>	
19. SIGNATURE OF CLERGYMAN <i>Rev. W. B. Brown</i>		20. SIGNATURE OF DECEASED <i>John A. Smith</i>	
21. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		22. SIGNATURE OF DECEASED <i>John A. Smith</i>	
23. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		24. SIGNATURE OF DECEASED <i>John A. Smith</i>	
25. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		26. SIGNATURE OF DECEASED <i>John A. Smith</i>	
27. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		28. SIGNATURE OF DECEASED <i>John A. Smith</i>	
29. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		30. SIGNATURE OF DECEASED <i>John A. Smith</i>	
31. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		32. SIGNATURE OF DECEASED <i>John A. Smith</i>	
33. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		34. SIGNATURE OF DECEASED <i>John A. Smith</i>	
35. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		36. SIGNATURE OF DECEASED <i>John A. Smith</i>	
37. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		38. SIGNATURE OF DECEASED <i>John A. Smith</i>	
39. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		40. SIGNATURE OF DECEASED <i>John A. Smith</i>	
41. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		42. SIGNATURE OF DECEASED <i>John A. Smith</i>	
43. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		44. SIGNATURE OF DECEASED <i>John A. Smith</i>	
45. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		46. SIGNATURE OF DECEASED <i>John A. Smith</i>	
47. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		48. SIGNATURE OF DECEASED <i>John A. Smith</i>	
49. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		50. SIGNATURE OF DECEASED <i>John A. Smith</i>	
51. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		52. SIGNATURE OF DECEASED <i>John A. Smith</i>	
53. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		54. SIGNATURE OF DECEASED <i>John A. Smith</i>	
55. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		56. SIGNATURE OF DECEASED <i>John A. Smith</i>	
57. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		58. SIGNATURE OF DECEASED <i>John A. Smith</i>	
59. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		60. SIGNATURE OF DECEASED <i>John A. Smith</i>	
61. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		62. SIGNATURE OF DECEASED <i>John A. Smith</i>	
63. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		64. SIGNATURE OF DECEASED <i>John A. Smith</i>	
65. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		66. SIGNATURE OF DECEASED <i>John A. Smith</i>	
67. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		68. SIGNATURE OF DECEASED <i>John A. Smith</i>	
69. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		70. SIGNATURE OF DECEASED <i>John A. Smith</i>	
71. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		72. SIGNATURE OF DECEASED <i>John A. Smith</i>	
73. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		74. SIGNATURE OF DECEASED <i>John A. Smith</i>	
75. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		76. SIGNATURE OF DECEASED <i>John A. Smith</i>	
77. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		78. SIGNATURE OF DECEASED <i>John A. Smith</i>	
79. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		80. SIGNATURE OF DECEASED <i>John A. Smith</i>	
81. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		82. SIGNATURE OF DECEASED <i>John A. Smith</i>	
83. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		84. SIGNATURE OF DECEASED <i>John A. Smith</i>	
85. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		86. SIGNATURE OF DECEASED <i>John A. Smith</i>	
87. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		88. SIGNATURE OF DECEASED <i>John A. Smith</i>	
89. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		90. SIGNATURE OF DECEASED <i>John A. Smith</i>	
91. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		92. SIGNATURE OF DECEASED <i>John A. Smith</i>	
93. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		94. SIGNATURE OF DECEASED <i>John A. Smith</i>	
95. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		96. SIGNATURE OF DECEASED <i>John A. Smith</i>	
97. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		98. SIGNATURE OF DECEASED <i>John A. Smith</i>	
99. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>		100. SIGNATURE OF DECEASED <i>John A. Smith</i>	

THE STATE DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13304

13311 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G. Meade</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21</u> <u>03-54-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>				d. STREET ADDRESS <u>1600 Gail Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> First <u>Samuel</u> Middle <u>THEODORE</u> Last <u>WILLEY</u>		4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>1958</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 Oct 58</u>	9. AGE (In years last birthday) yrs. <u>2</u> Months <u>3</u> Days <u>5</u> Hours <u>Min.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Hursel Junior Willey</u>				14. MOTHER'S MAIDEN NAME <u>Helen Marie Alderman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father</u> Address <u>Hursel J. Willey 1600 Gail Rd, Baltimore, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>334X</u> DUE TO <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral edema</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 HR</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>22 Dec</u> , 19 <u>58</u> , to <u>22 Dec</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>22 Dec</u> , 19 <u>58</u> , and that death occurred at <u>1130 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Army Hospital, Ft Meade, Md</u> DATE SIGNED <u>22 Dec 58</u> ACTUAL SIGNATURE <u>Fred W. Lafferty</u> M.D. PHYSICIAN'S NAME (Type) <u>FRED W. LAFFERTY, CAPT, MC, U.S. Army Hospital, Ft Meade, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>12-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Charleston Cemetery</u>		22d. LOCATION (City, town, or county) <u>Charleston, West Virginia</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

2050236XV8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13312 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13300

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. LENGTH OF STAY IN 1b <u>5 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis Rd.</u>			d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Tony Wojenkotis</u> First <u>(Alvus)</u> Middle <u>Wagenkutus</u> Last			4. DATE OF DEATH December 18th. 19 58		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/24/91</u>		9. AGE (In years last birthday) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lithuania, Europe.</u>	12. CITIZEN OF WHAT COUNTRY? <u>Lithuania</u> ✓
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>213-09-1230</u>		17. INFORMANT <u>Mr. James E. Karzeglow (employer)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Ritchie Hwy</u>	(County) <u>Montgomery</u>	(State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/18/58</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 20 '58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy, Montg. Co., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard C. Frank</u>		ADDRESS <u>Eden Runne md</u>		24a. REC'D BY REGISTRAR <u>DEC 23 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

